



DOCTORAL THESIS

Counselling Psychologists' perception, understanding and experience of client dependency within the overall therapeutic relationship and its impact on the therapeutic process

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Counselling Psychologists' perception, understanding and experience of client dependency within the overall therapeutic relationship and its impact on the therapeutic process

by

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Counselling Psychologists' perception, understanding and experience of client dependency within the therapeutic relationship and its impact on the therapeutic process

ABSTRACT

The aim of the research was to examine how Counselling Psychologists perceive dependency in their clients and also how they experience the phenomenon in their therapeutic practice. Research suggests that dependency is relevant to the formation and continuance of relationships and that it can influence the strength and quality of those relationships and as such has a role in therapeutic relationships. Open-ended semi-structured interviews were conducted with 8 Counselling psychologists with in excess of 5 years experience. Interviews were recorded, transcribed and analysed using Interpretative Phenomenological Analysis. 4 master themes were identified. 'The therapeutic relationship as the context for dependency' was consistent with existing literature on the importance of the therapeutic relationship. Participants were generally resistant to clients becoming dependent on them and maintained firm boundaries to avoid it and believed that greater experience made it easier to work with dependency. Participants' reluctance to approach dependency issues was consistent with western societal values that seem to reject vulnerability and neediness. Significant for training and practice was the theme 'feelings engendered by dependency', with challenging reactions to dependency rarely being discussed in training or supervision and for which there is little professional support. The theme 'impact of the theoretical approach and environment on dependency' suggests that longer term therapy, such as psychodynamic approaches, encourage an over reliance on the therapist. The fourth theme 'power', indicated that participants recognised the influence of power in therapy and in general felt empowerment was an appropriate therapeutic goal.

CHAPTER 1

INTRODUCTION

Counselling Psychologists' perception, understanding and experience of client dependency within the therapeutic relationship and its impact on the therapeutic process

BACKGROUND

The aim of the research was to contribute to knowledge and understanding of how Counselling Psychologists, who are concerned with the integration of psychological theory and research with therapeutic practice (British Psychological Society (BPS), 2008) understand and experience the phenomenon of client dependency in the context of the therapeutic relationship.

An interest in the phenomenon of dependency arose from the researcher's experience of personal therapy as a precursor to Counselling Psychology training, where weekly sessions were attended for over 3 years as a course requirement. The researcher's therapist practised using a humanistic approach, which was non-directive and featured minimal self-disclosure. Initially the researcher felt disconnected from her therapist, which continued throughout the first year of therapy. The interaction between the therapist and client felt distant and the researcher gave the therapist very little thought between sessions. In this context the researcher questioned how this lack of connection might impact the quality and

ultimately the effectiveness of the therapeutic experience. The researcher began to question the impact of both a resistance to dependency or an excessive reliance on therapy and became interested in therapists' understanding of the phenomenon and their experience of it in their practice. In particular the researcher was concerned to learn how Counselling Psychologists' experience of dependent clients impacted them personally.

The researcher was aware that different theoretical stances have been taken on the role of dependency in therapy. Freud (1944) believed that in every psychoanalytic relationship 'an intense emotional relationship between the patient and the analyst' developed (p. 75), referring to this as transference. Ellis (1979), a rational emotive behaviour therapist, was sensitive to how therapist behaviour could foster dependency, arguing that it was not appropriate for therapists to be particularly warm towards their clients because this might reinforce a client's dependency and be counter-productive for the client in the long term. Dryden (2006) regarded object relations therapy, which fosters a safe and caring therapeutic relationship, encouraged independence and the development of a more autonomous self, whilst still nurturing the establishment of intimacy and trust between the client and the therapist. This is consistent with the views of Winnicott (1965, p.5) who saw independence as something that is achieved out of dependence and as occurring only if 'a very sensitive adaptation is made by someone to the infant's needs'. Rogers (1951), when writing about transference in the context of person centred therapy, observed that 'the emotionalized, dependent relationship between the

client and the therapist almost always becomes the heart and focus of successful analytic therapy , whereas this does not seem to be true of client centred therapy' (p.218). Accordingly, the researcher wanted to investigate how the therapeutic approach being practiced by therapists might influence dependency and how it might be worked with in the context of a therapeutic relationship.

Context of the research

Rogers (1958) came to believe that the quality of the relationship between therapist and client was more important in therapeutic change than any specific techniques used by the therapist; specifically the therapist's congruence, unconditional positive regard and empathy. Khan (1996 p.13) thought that 'the relationship is the therapy'. Relatedness is seen as central to human relations, with people existing as members of groups and as partners in inter-personal relationships. Deci and Ryan (2006b) in their theory of self-determination, which hypothesises that individuals have an innate tendency towards psychological growth integrating experience into a coherent sense of self, identify both relatedness and autonomy as key psychological needs. Bowlby (1969), in his work on attachment, also recognised the interplay between relatedness and dependence, noting that a truly self-reliant person was not an independent individualist but rather someone who secured close personal relationships. Within the context of the therapeutic relationship, which it has been suggested comprises a number of elements (Clarkson, 1990a), clients may develop a dependency on their therapist, which can vary in quality and intensity depending upon the nature

and duration of the relationship (Heller and Goldstein, (1961). In addition to factors such as empathy, warmth, understanding and trustworthiness, which impact the quality of the therapeutic relationship (Ackerman and Hilesenroth, 2003), dependency has been found to be necessary for establishing a good working alliance (Bordin, 1979) and as central to the effectiveness of therapeutic work. In particular it has been found to be a factor affecting whether individuals seek therapeutic help in the first place (Sroufe, Fox and Pancake, 1983); how long it takes them to seek help (Greenberg and Fisher 1977); what issues they take to therapy (Bornstein and Johnson, 1990; Conley, 1980); the length of time spent in therapy (Greenberg and Bornstein, 1989) and also the quality of therapeutic outcome (Bornstein 2005).

The existing research on dependency is not particularly up to date and where it exists has in the main been conducted in the medical arena using quantitative methods and, whilst this has sometimes included mental health, little research exists into dependency in the context of purely therapeutic relationships, which the researcher is seeking to explore. An explanation for this may be that research into a concept developed from psychodynamic principles and closely related to (although distinguishable from) attachment (Bowlby, 1969; Ainsworth, 1969) has been subsumed into research on attachment theory and in particular its role in the therapeutic relationship (Main, 2010). A further explanation for the lack of current research on dependency may be that in therapeutic relationships the phenomenon has been absorbed into thinking on power. House (2008) has identified as a 'thorny

issue' whether clients would consent to entering into the therapeutic process if they realised upfront that therapy would involve issues of power and control. These issues relating to power in the therapeutic relationship are topical in psychological therapeutic circles with the current movement towards regulation being predicated on protection of the public from potential abuse of power.

Rationale and purpose of the research

Investigating how Counselling Psychologists experienced the phenomenon of dependency in their clinical practice was to gain in-depth insight into the nature of that experience. The purpose was to gain an understanding of their approach to dependency (whether it is something they foster or discourage), to discover how they personally experience dependent clients when it was encountered in their practice, what impact it had on them and how they believed it affected their work with the client.

The research was conducted using interpretative phenomenological analysis (Smith, 1996) (IPA) with the aim of obtaining rich, elaborated descriptions from participants of their personal lived experience of dependent behaviours in their clients and how they make sense of that personal lived experience (Smith, 2004). It was also intended that some insight be gained into how Counselling Psychologists, who have not previously contributed to research on dependency, understand the phenomenon and how they believe it impacts their practice. In contrast to

realist/post-positivist paradigms based on the philosophical ontological assumption that reality exists, IPA assumes that meaning emerges through interaction between individuals. As meaning is co-constructed it cannot be directly observed but rather interpreted (Haverkamp and Young, 2007). IPA recognises the central role of the researcher in making sense of the participant's personal experience (Smith, Flowers and Larkin 2009) and that it is through this interaction that knowledge and meaning emerges. As researchers' values are assumed to influence the research process researcher, reflexivity is vital.

With its roots in phenomenology, hermeneutics and ideography, IPA's use in psychological research has been relatively short lived, initially being used in health psychology. Latterly it has been used in social, clinical and counselling psychology research (Smith et al. 2009) with a number of papers being published (Knudson and Coyle, 2002; Rhodes and Jakes, 2000). A wide variety of topics have been researched and whilst there are a number of studies concerned with aspects of therapeutic intervention, using IPA to analyse data gathered from Counselling Psychologists about their experience of dependency in the therapeutic relationship, does develop and extend its use beyond its current bounds. Using IPA in this context has also provided an opportunity to explore its effectiveness as a methodology suited to the exploration of therapeutic practice for which it has to date been seldom used (Carradice, Shankland and Beail, 2002).

Whilst there is ongoing debate amongst researchers, therapists and policy makers about what constitutes evidence in support of therapeutic interventions, with randomised control trials being seen as the gold standard for establishing treatment efficacy (National Institute for Health and Clinical Excellence (NICE) Guidelines, 2009), the research conducted does provide additional and novel information to fuel the debate on dependency, which is a phenomenon that impacts the therapeutic relationship and therapeutic outcome. This research sheds light on how Counselling Psychologists, who take a pluralistic approach and who regard the therapeutic relationship as central to their work, experience their clients' dependency needs and how they work with those needs if they arise. Also whether they cultivate dependency in their therapeutic relationships and what impact they believe it has on the course and outcome of therapy. The researcher believes that the findings will inform ways of working with clients who become dependent or who may have dependency needs and who may tend to be more vulnerable as a client group. The findings also indicate that the impact on a therapist of a dependent client is something that needs to be more fully examined and discussed in training programs and is something of which supervisors should have greater awareness.

CHAPTER 2

LITERATURE REVIEW

In the context of conducting research into a phenomenon it is important to ensure that clarity exists, to the extent it is possible, on the meaning of the phenomenon being investigated. To that end the researcher has conducted a detailed search of relevant literature that examines and seeks to define 'dependency', including a review of the origins of the term, which is summarised in the paragraph below. The researcher has in addition conducted a review of the literature on attachment because of its close relationship with dependency and also included some literature on power. Brief reference is also made to the literature on therapist's feelings because of the numerous references made by participants to the feelings they encountered when experiencing dependent behaviours in their clients or the anxiety they felt in anticipation of such behaviours.

In order to understand the phenomenon of dependency it is important to understand the theories that inform it. Client dependency has been seen as a strength and a weakness, in some cases increasing the likelihood of psychopathology and in others enhancing the effectiveness of therapy (Bornstein and Bowen, 1995). The evidence suggests that early childhood experiences influence adult dependency needs which may mean that there is little participant Counselling Psychologists can do to influence a client's dependency on them. Some

support for this can be seen in Bornstein's (2005) research, which found significant correlations between individuals with dependent personality disorder, as defined in version IV of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV), and dependent behaviours in a therapeutic context. Alternatively, as suggested by Rogers (1951), whether the therapeutic approach sees the therapist as expert or instead validates the clients view on their problems may have an influence on whether dependency arises.

Definitions

In 1993 Bornstein (p.18) had concluded that there was no 'universally accepted operational definition for dependency' and when talking about dependency the participants used a variety of terms to describe the phenomenon. As a starting point the researcher therefore consulted dictionary definitions of the term. The Oxford English Dictionary (1973) defines dependency as the condition of 'being dependent'; as 'having a contingent, logical or causal connection to that by which it is supported'; as and something 'subordinate'. Being dependent is defined in relation to a person as 'having ones existence contingent on another' and as 'being dependent on another for support or what is needed'. Webster (1913) further defines dependence as a state of 'being subordinate'; 'having a connection to another' and as including 'reliance' and 'trust'. He defines dependency as 'the state of relying on' or 'being controlled by someone or something else'. Collins (1999) thesaurus adds to this with the concept of 'being influenced by another' and as

‘having trust in; to bank on; to build upon; confide in; to rely on; to lean on and revolve around another’.

In the absence of a psychological definition Bornstein (1993) went on to conceptualise dependency as being based on four factors, which the researcher has found illuminating in terms of understanding the concept of dependency. He defined it as consisting of a motivational aspect (a need for guidance, approval and support from others), a cognitive aspect (a perception of the self as powerless and ineffectual whilst others are powerful), an affective aspect (a tendency to become anxious when having to function independently) and a behavioural aspect (a tendency to seek help, approval, reassurance and guidance from others). In the literature the terms ‘dependence’ and ‘dependency’ are used interchangeably. Whilst their definitions are synonymous the researcher has chosen to use the term ‘dependency’, which has in the literature been associated with regression, symbiosis, attachment, helplessness, passivity, lack of autonomy, and to refer to an infantile developmental phase of oral and symbiotic needs (Steele, Van der Hart and Nijenhuis, 2001). The term dependency has also been paired with adjectives, such as ‘unhealthy’ ‘malignant’ ‘regressive’ ‘manipulative’ ‘resistant’ or ‘immature’, conveying something negative. Consistent with this, participants used adjectives such as ‘needy’ and ‘unhealthy’. Dependency has also been compared to a preferred state of independence, with the implication that any traces of dependency should not be present in healthy mature adults (Steele, et al. 2001).

DSM-IV offers a definition of dependency in the context of Dependent Personality Disorder defining the disorder's essential feature as a 'pervasive and excessive need to be taken care of that leads to submissive and clinging behaviour and fears of separation, with the dependent and submissive behaviours designed to elicit care giving'. Dependency based behaviour is said to arise from 'a self-perception of being unable to function adequately without the help of others' (American Psychological Association, 2000, p. 721). The DSM-IV definition goes on to give examples of dependent behaviour as difficulty in making decisions without excessive advice; needing others to assume responsibility for most major areas of life; difficulty in expressing disagreement; difficulty in initiating projects or doing things alone; going to excessive lengths to obtain nurture and support; feeling helpless when alone; urgently seeking another source of protection when a relationship ends and being preoccupied with fears of being left to care for oneself.

Historic development of the term 'dependency'

In order to examine Counselling Psychologists' perception and understanding of dependency arising in their therapeutic relationships with clients it was a pre-requisite for the researcher to have an in-depth understanding of how that term is understood and used by psychologists. This required an exploration of the historic development of the term dependency and tracing its development to date.

Psychologists have historically given a great deal of attention to the concept of dependency. This is seen in three distinct stages. Firstly, with the rise to prominence of the dependency concept researched extensively by Sears, Maccoby and Levin (1957) in their series of studies of young children and the impact of their mother's behaviour on dependency needs. They concluded that her repeated demonstration of affection and warmth towards her child supported the actions taken by the child in order to secure the mother's demonstration of affection. The child's actions involved following the mother around, touching her, smiling and talking to her and generally finding ways to maintain contact with her. Sears et al (1957) labelled these actions as dependent behaviours. Next came the assimilation of the ethological concept of attachment to the dominant dependency paradigm which led to the terms attachment and dependency being used interchangeably (Gewirtz, 1972; Maccoby and Jacklin 1974) and then later the separation of the two concepts and the ascendancy of attachment (Ainsworth, 1969; Maccoby 1980).

Dependency as a concept has its origins in a wide variety of psychological theories. The psychoanalytic model (Freud, 1905), which informed the object relations model and attachment theory; the social learning model of dependency (Walters and Parke, 1964); and ethological theory (Ainsworth, 1969) are all influential in terms of seeking to explain dependency. Originally dependency was considered to be a trait concept, referring to individual differences in the need for comforting, approval or attention (Hartup, 1966). Learning theorists then regarded it as an acquired drive learned in conjunction with the normal care giving process (Sears et al, 1957). In his

work on the psycho-sexual stage model Freud (1905) believed that orally dependent traits would indirectly influence the health of the individual by virtue of habits and behaviours that would increase the risk of ill-health such as over eating and excessive use of alcohol. Whilst the psychoanalytic model and the social learning model of dependency differ in terms of their emphasis on oral behaviours as a determinant of dependency, they both recognise cognitive processes as being relevant to the behaviours exhibited by dependent individuals in different situations. In the psychoanalytic model, mental representations of the primary carer influence the extent to which dependency needs are experienced, whereas it is the expectation of punishment or reward that influences behaviour in social learning theory. It may be because of the wide variety of origins used to understand the construct of dependency that there is no agreed universal definition.

Classical psychoanalytic theory (Freud, 1905) links dependency to the oral stage of development, with infants who were either frustrated or overindulged during this stage later developing dependency behaviours. Freud postulated that orally fixated individuals will remain dependent on others for nurture and support into adulthood and will continue to exhibit behaviours that reflect the infantile oral stage as a means of coping with anxiety or stress in adulthood. This may help to explain why individuals who are dependent on alcohol and substances have been shown to exhibit high levels of dependency (Bornstein, 1992). This link was made by 3 participants who worked with alcohol and substance dependent clients, describing their clients as frequently transferring that dependency to a dependency on their

therapist. Whilst they all saw it as an inevitable risk of their work, one participant regarded it as something to be feared, another as something to be discouraged and the third took active steps to discourage any dependency on him. Glover (1925) extended Freud's classical model by suggesting that oral frustration and oral gratification would lead to different dependent personality styles. Whilst research by Goldman-Eisler (1951) provides some support for this extension of Freud's (1905) classical theory, it has some methodological flaws, relying uncritically on retrospective self-report of participants. Notwithstanding numerous empirical studies testing various components of the theory its influence waned because the link between high levels of dependency and a preoccupation with food or other oral activities could not be established (Bornstein, 1992).

Social learning theory dominant in the 1940's and 1950's mirrors psychoanalytic theory in relation to dependency in that it regards the origin of interpersonal relations as starting with an infant's dependence on its mother and sees dependency as 'a class of behaviours, learned in the context of the infant's dependency relationship with his mother' (Ainsworth, 1969 p.970). Dependency was considered to be an acquired drive learned in conjunction with the normal process of care giving in that the individual learns to associate the presence of the care giver with the gratification of other drives and so contact with people is assessed as valuable (Sears et al, 1957). There was a shift from drive based theory to an object relations approach where personality was conceptualised in terms of

the 'self' and 'others' with a focus on the internalisation of representations of the self and significant others.

In object relations theory dependency is seen primarily in terms of a child's journey from complete reliance on their primary carer to a time when they are able to meet both their own physical and psychological needs. It is generally agreed that the first object, through which the instinctual needs are met, is the mother (Ainsworth, 1969). In his object relations theory of dependency Fairbairn (1952a), who believed that newborn babies manifest object seeking behaviour, emphasises separation, individuation and development of self-concept in early childhood as critical. He saw the relationship between child and carer as a prototype for future relationships, believing the libidinal drive towards good object-relationships was a fundamental fact of human nature. He felt that the significance of human living lies in object-relationships, and only in such terms can our life be said to have meaning, 'for without object-relations the ego itself cannot develop' (Fairbairn, 1952a, p.33). A child is thought to become dependent if its mother is over indulgent because this results in the child coming to believe that others will cater for them similarly. Alternatively if the mother is absent as a nurturer a child may become increasingly demanding of others in a bid to have their unfulfilled needs met; the result being that the absence of secure internal objects results in dependency needs being exhibited (Bornstein, 2005). Winnicott (1965), who was not explicit about the origins of the infant-mother tie, rather seeing 'holding' as covering the total environmental provision for an infant, saw independence as something that is

achieved out of dependence and as something that cannot occur 'unless a very sensitive adaptation is made by someone to the infant's needs' (p.5).

Bowlby (1958), in the course of proposing a new approach, based on ethological principles, to the origins of a child's tie to its mother, maintained that for children to grow towards independence and the establishment of an ability to meet the needs of others it is necessary for them to have their own needs met. A parallel can be seen to operate in therapy where the therapist is initially able to meet the dependency needs of their client within the realm of the therapeutic relationship and then as the client grows towards independence is able to wean the client from dependency, becoming independent and more able to rely on their own resources. Allowing strong infantile feelings of dependency to occur and then work with these was seen as a vital part of the therapeutic process by one Counselling Psychologist participant, who worked using a psychoanalytic model in her private practice.

The transition from reliance on the mother to a state of mature independence recognised in object relations theory is echoed in the attachment theory of Bowlby, (1969; 1980), Ainsworth (1969) and Main, Kaplan and Cassidy (1985) with both theories regarding the overall quality of the relationship with the primary caregiver during early childhood as the main determinant of dependency behaviour in adults (Ainsworth, 1969). It is recognised that although the first dependency relationship is specific, usually to the mother, it later generalises to subsequent interpersonal

relationships. It is the degree to which passive dependent behaviour was reinforced by the primary carer that affects dependent behaviours in adults (Ainsworth, 1969) which acts as a model for later inter-personal relationships (Bowlby, 1988).

Bornstein (1995) suggests that the absence of secure internal objects is likely to result in dependence in adulthood and Bowlby (1969) emphasises the innate underpinnings of the mother-child bond as the primary determinant of self-concept and future behaviour. The tension between dependence and individuation (the desire to separate versus the desire to re-merge with the primary caregiver) which is identified in object relations theory and attachment theory can be seen in other psychological phenomena such as romantic love and the strong identity adopted by some with religious groups. This tension may well be evident in some therapeutic relationships and particularly so where the therapist represents a nurturing supportive object for the client. In these circumstances the desire to merge with the therapist on the part of a client who has dependency tendencies may be hard to resist.

Blatt and Levy's (2003) object relations framework, which has influenced an object relations/interactionist model of dependency, integrated concepts from object relations theory and cognitive psychology. They have argued that dependent personality traits result from the internalisation of mental representations of the self as weak and ineffectual. The main influences of this internalisation process is said to be authoritarian and over protective parenting, which prevents the development of a sense of autonomy and sex role socialisation (Sroufe , Fox and

Pancake, 1983) (see below for a discussion of the literature on gender related issues). Authoritarian parenting leads to the belief that the way to maintain good relationships is to rely on others for guidance and protection and to acquiesce to the demands of others, whereas over protective parenting leads to children believing that others will always protect and support them.

The Relationship between Dependency and Attachment

A historical link exists between attachment theory and psychoanalytic theory from which the concept of dependency emerged but research on attachment theory has principally been pursued by developmental psychologists, who were influenced by ethological rather than psychoanalytic principles. Notwithstanding the difference in origin, the literature treats dependency and attachment as being closely related with Gewirtz (1969) using similar concepts to account for both, with attachment seen as a form of dependence of the behaviour systems of one person upon the unique physical and behavioural stimuli provided by a particular person whereas dependency related to a larger number of unspecified individuals. As a consequence of this close link it seems important to examine these concepts together in order to gain a full understanding of what is meant by the term dependency, central to the research question.

In the literature dependency is treated as a manifestation of attachment that includes a wide-ranging set of conscious and unconscious behavioural strategies that reflect affect and cognitions (Bornstein, 1995; 1998). The purpose of

dependency, as opposed to attachment, is specifically to procure care taking. There is seen to be a need for direct support and guidance from an attachment figure such that adequate activation of inborn emotional systems designed to maximize adaptation to normal daily life can be promoted (Steele et al. 2001). Attachment is regarded a broader concept in that attachment behaviours may not necessarily specifically involve procurement of direct care-taking, but can just involve proximity to an individual or merely an internal sense of felt security derived from the attachment. Unlike attachment, dependency is not confined to a particular developmental phase, but can change in nature and expression throughout life. It varies in intensity and manifestation according to situational and interpersonal factors, and to alterations in an individuals' capacity for the type of activity that promotes balanced levels of interdependency, intimacy, and autonomy (Steele et al. 2001).

Further confirmation of the close relationship between dependency and attachment is evidenced by the research of Sroufe et al. (1983) which found children who exhibited insecure attachment styles also showed strongly dependent behaviours (Sroufe et al, 1983). The relationship is also supported by the five dimensions of attachment and dependency developed by Livesley, Schroeder and Jackson (1990) in which they conceptualized dependency as being made up of both attachment and dependency needs, comprising in the case of attachment the following feelings and/or behaviours: fear of loss of an attachment figure; the need for affection; the need for proximity to the attachment figure; feelings of security

based on physical presence of attachment figure and strong protest at separation from the attachment figure. In the case of dependency comprising: low self-esteem; the need for advice and reassurance; the need for constant reassurance and approval; the need for care and support and submissiveness. These feelings and behaviours are seen as adaptive and are understood to occur on a continuum (Livesley et al. 1990).

Ainsworth (1969) wrote that both dependency and attachment are acquired by a conditioning of various behaviour systems such as approach, orientation, regarding, following, remaining near, touching, smiling, and vocalizing in relation to a specific person or to a class of persons. Attachment behaviour has biological underpinnings based on the concept that human beings have a propensity to form strong affectional bonds (Bowlby, 1958). Infants have an innate capacity to form a secure sense of self and the world provided that primary carers are accessible and responsive to their needs for comfort and protection (Bowlby, 1988). This can result in long lasting psychological connectedness to another human being.

Bowlby (1958) initially saw attachment as fixed from cradle to grave. However, more recent research suggests that it is possible to earn secure attachment in adulthood (Main, 1996). Attachment is either secure or insecure and extensive research supports the existence of four attachment styles: secure, anxious-ambivalent, avoidant and disorganised (Ainsworth, 1969). Individuals with an

anxious-ambivalent attachment style have a tendency to make excessive demands of others, be clingy when they are not met and perhaps hold less positive views about themselves, doubting and blaming themselves for another's lack of responsiveness (Bowlby, 1969), and they may also exhibit high levels of emotional expressiveness and impulsivity in relationships (Hazan and Shaver, 1990). Those with avoidant attachment styles tend to seek less intimacy, avoiding rejection by distancing themselves from others, whereas those individuals with disorganised attachment styles are likely to exhibit a spectrum of the behaviours evident in the other three attachment styles.

It is thought to be deficiencies in care giving during a child's formative years that produce a pattern of insecure attachment, which can adversely impact the formation of adult inter-personal relationships and influence how an individual anticipates and construes self and others in relationships (Bowlby, 1969). The relationship between dependency and attachment can be summarised as follows: Attachment behaviour results in retaining proximity to a preferred individual, who is perceived as stronger or wiser, whereas dependency behaviours are not directed towards a specific individual, being more generalised and intended to elicit assistance, guidance and approval from others in general (Livesley et al. 1990). During the 1970's and 1980's major advances in the study of early social development resulted in the establishment of a conceptual distinction between attachment (the relationship between infant and caregiver) and dependency (the reliance of the child on adults for nurturance, attention, or assistance). This

distinction then made it possible to investigate the relationship between infant-caregiver relations and subsequent over-dependency. In a study in 1983 Sroufe et al investigated this link by assessing children with varying attachment histories in a pre-school setting and found that children classified at 12 and 18 months as avoidant (Ainsworth, 1969) were highly dependent whereas children, who were securely attached were significantly lower on the same measures and significantly higher on 'seeking attention in positive ways.' These results support thinking that the roots of over-dependency, like attachment issues, lie in the quality of the early infant-caregiver relationship.

Like attachment, dependency has been referred to as secure and insecure (Slade, 1999) with insecure dependency tending to be expressed as excessive dependency or excessive inter-dependency. Dependency can also be active or passive; positive or negative (Bornstein, 1995). Positive manifestations of active dependency relevant to seeking therapeutic help include cooperation, active help seeking, and positive attachment to the therapist. Negative manifestations include a sense of entitlement, extreme demanding behaviour, and a high degree of neediness that cannot be processed or contained. When encountered either in a therapeutic or a non-therapeutic environment such behaviours risk the withdrawal of the attachment figure and indicate that the individual concerned is insecurely attached. Passive dependency includes helplessness, submissive behaviours, passivity, indecision, and general suggestibility. Positive aspects include compliance with treatment (Bornstein and Masling, 1985) and positive suggestibility (Tribich &

Messer, 1974) whereas negative aspects include an inability to act, indecision, a strong need for intimacy and affiliation (Hollender, Luborsky and Harvey, 1970) and fear of negative evaluation by others (Goldberg, Segal, Vella and Shaw, 1989). Both active and passive dependency behaviours appear to be designed to attain secure attachment in that emotional systems are activated when an important relationship with a care taking figure seems threatened (Bornstein, 1995), or when separation anxiety otherwise occurs (Panksepp, 1988). Bowlby (1969) believed that clients were likely to form attachments to their therapists and so an individual's attachment style will have an impact on the relationship that forms between them and influence how the therapist experiences them, with those who are insecurely attached potentially exhibiting dependent behaviours. Those who are securely attached are likely to be comfortable with both intimacy and independence in their relationships (Hazan and Shaver, 1990) including in their relationship with their therapist.

Conclusions of the review of the theoretical background to dependency and the relationship between dependency and attachment

Whilst the theories summarised above have contributed to an understanding of dependency, notwithstanding the amount of attention historically dedicated to examination and investigation of the term, as a concept it remains a somewhat elusive and poorly understood phenomenon, with continued disagreement over its exact definition and relationship to attachment (Steele et al. 2001). However, the

close association between attachment and dependency, outlined above, has proved helpful in understanding the role dependency is likely to play in the relationship between the therapist and client with both Bowlby (1988) and Bornstein (2005) respectively regarding attachment status and dependency as relevant to psychopathology. Particularly helpful in aiding understanding of the phenomenon is Bornstein's (1993) definition which suggests dependency is associated with cooperativeness, compliance and interpersonal yielding and his contention that it includes four aspects (a motivational aspect relating to the need for support and approval; a cognitive aspect relating to feelings of powerlessness; an affective aspect relating to anxiety in the face of autonomy and a behavioural aspect relating to self-presentation strategies used to strengthen ties to caregivers) (Bornstein, 2005). Also potentially helpful to understanding how dependency may be experienced by Counselling Psychologists in their practice are the examples of dependent behaviour in DSM-IV, although two of the descriptions have been contradicted by empirical research and another two have never been tested (Bornstein, 1993).

Research on Dependency

As a consequence of the researcher's particular interest in Counselling Psychologists' perception, understanding and experience of client dependency in the context of the therapeutic relationship an extensive review of the literature relating to dependency in therapy was conducted. It was found that, whilst

extensive historic research exists, very little current research on dependency generally and more particularly on dependency in therapeutic or other helping relationships exists. The absence of current research led the researcher to consider possible explanations for this and also to contact Robert Bornstein the researcher of much of the historic research. This resulted in an exchange of emails in which he said that whilst he was uncertain as to why interest in studying dependency in therapy has fallen off in recent years his feeling was that it might have something to do with the move away from the trait approach to the measurement of individual differences in personality in favour of the Five Factor Model (Costa and McCrae, 1985), which he thinks 'has tended to push other personality traits/styles not included in the five factors to the margins'. Alternatively he felt it might 'reflect a more general shift away from investigating individual difference variables as moderators of therapy process and outcome'. He went on to say that he was 'starting to think that dependency might actually turn out to be a more useful moderator of health and health service use than of psychopathology or therapy process or outcome' but that this requires further research evidence (Personal conversation with Robert Bornstein).

A further explanation for the lack of current research may be that notwithstanding their different origins (dependency: psychoanalytic; attachment: developmental) the close relationship between the concepts may have resulted in thinking on dependency being subsumed by studies on the role of attachment style as determining the quality of key relationships (Main and Cassidy 1988) including

therapeutic relationships (Bowlby, 1969). The impact of attachment style in therapy has been researched by Main (1996), who developed the Adult Attachment Interview from which an adult's attachment style can be determined. She has further developed the use of the adult attachment interview by suggesting ways the questions it contains can be used by therapists when working with clients in order to shed light on their style of relating both with the therapist and with other individuals (Main, 2010). It is also possible that dependency in therapeutic relationships has been incorporated into thinking on the role of power in those relationships. Power has been explained as something that presses on the individual from the outside and as what subordinates a lower order (Bultler, 1997). Foucault (1972) understood power as something that formed the individual as well as providing the condition for their existence. In this sense power is what individuals both depend upon for their existence and what they harbour and preserve in themselves as beings. Power and control are evident in all relational dynamics (House, 2008) and thus it is possible to see therapy, because of the expertise wielded by the therapist (often seen as a quasi medical professional), as a place where clients give away their power. In this context an abuse of the professional process can take place routinely albeit without any conscious dishonesty on the part of the therapist. In her qualitative research on whether dependency was a means or an impediment to growth Tait (1997) found that clients sometimes believed that dependencies were created by therapists as a result of their inexperience or as an abuse of power. Totton (2006) also claims that the structure of psychotherapy builds in stubborn problems of power and control and consequently a critical psychoanalyst must recognise their immersion in power

dynamics and engage in deliberate reflection on his or her position within them, both inside and outside of the consulting room (Hook, 2003).

There seems to be a connection between the idea that therapy is an environment in which power is surrendered to 'a regime of expertise' (Totton, 2006) and Bornstein's (2005) explanation that the thoughts, feelings and behaviours of dependent individuals revolve around the need to closely associate and rely upon other valued individuals. Foucault (1972) believed that individuals are passionately attached to their own subordination and where they sustain their subordination they can be said to be responsible for it. This attachment to subjection is hypothesised to occur through the psychological effects of the workings of power (Butler, 1997). Foucault's notion that subjection acts as the simultaneous for both the forming and the subordination of the individual it can be seen to have psychoanalytic foundations, provided it is accepted that no individual can survive without forming an attachment to those on whom they are dependent for their survival. Butler (1997) believed that it was the formation of this necessary dependency that rendered the child vulnerable to subordination and exploitation. Clients will inevitably seek to fit the object-relationship with their therapist into their template of past relationships with key individuals. Consequently there is a connection between childhood experiences of subordination and their re-experience in therapy and to how dependency plays out in the therapeutic relationship.

Potential abuse of power in therapeutic relationships is topical in therapeutic circles with the current movement towards regulation being predicated on protection of the public. The move towards greater public access to therapy, started under the Improving Access to Psychological Therapies (IAPT) initiative of the previous government, with its focus on cognitive behavioural therapy delivered in up to 20 sessions, is shorter term with less focus on the therapeutic relationship and as such guards against client dependency.

Having suggested an explanation for the absence of current research on dependency, what is available in the literature is summarised below and is helpful to aid understanding of why dependency may arise in therapeutic relationships and also how dependency might manifest itself within that context.

Research on suggestibility, yielding and compliance

Bornstein (1992 p.18) maintained that 'one central goal underlies much of the dependent person's behaviour: obtaining and maintaining nurturing, supportive relationships.' He identified dependent individuals as more suggestible, yielding and compliant than others; being help-seeking and experiencing performance anxiety as a result of evaluation by authority figures.

Suggestibility

Tribich and Messer, (1974) in their research using under-graduates found that dependent individuals are more suggestible than others, being more strongly affected by high status individuals, such as doctors and other medical professionals. These findings supported earlier research findings of Jakubczak and Walters (1959) who conducted some of the first research into the relationship between dependency and suggestibility. Using a sample of 24 children they conducted an experiment in which erroneous judgements were made about movement of a light source by low and high status individuals. They found that dependency was associated with increased suggestibility and that this was particularly pronounced when the source of the information was a high status individual as opposed to a peer. Ojha (1972) similarly found that political slogans were given greater credibility by dependent individuals of both sexes when they were associated with high prestige individuals. This research suggests that dependent individuals who undergo therapy may well be significantly influenced by their therapist, which may in turn feed their dependent behaviour.

Yielding

Research into dependency and personal yielding is consistent with the above findings on suggestibility, with Kagan and Mussen (1956) using Asch's (1956) conformity paradigm finding that dependent individuals are more likely to acquiesce with the erroneous opinions of confederate participants in experiments

where the length of lines was being judged. However, contradictory results were found in an experiment using undergraduates by Bornstein, Masling and Poynton (1987) where dependent individuals were less likely to change their mind having decided on the gender of a poet. This result can be explained by information gathered in interviews conducted following the experiment where dependent participants made it clear they had been concerned to make a good impression on the researcher and were therefore loath to change their mind having made a decision. Thus when confronted with the option of impressing an authority figure or getting on with a peer they chose the former.

Compliance

A number of studies have been conducted into the relationship between dependency and compliance. In an experiment using 120 male and female undergraduates who were asked to continue until they had solved 4 puzzles, 2 of which were unsolvable, Agrawal and Rai (1988) found that individuals with the highest dependency scores, judged using a well established measure, continued the longest. Similar results were found by Weiss (1969) where students were asked to estimate the number of dots on slides they were shown believing they were participating in an experiment on perception. Dependent individuals over estimated the number of dots in accordance with the stated expectations of the researcher whilst non-dependent individuals showed very little compliance. In an experiment involving psychology students, who were required to participate in experiments as part of their course requirements, dependent students completed their

participation far earlier than other students, suggesting they would do so in order to please their tutor.

The studies summarised indicate consistent results which show that dependency is associated with a general tendency to be influenced by the opinions of others, to yield to others in inter-personal transactions and to comply with the expectations and demands of others. In these circumstances it is possible to see that a therapist's views might be highly influential to a dependent client who may be particularly cooperative with their therapist.

Help Seeking, inter-personal sensitivity and affiliation

Given that dependent individuals are concerned with being supported and nurtured and are also in need of guidance, particularly from high status individuals, it follows that they are also likely to exhibit certain help-seeking behaviours in order to elicit the support required. Connected with this is the extent to which they can accurately infer the attitudes, beliefs and feelings of others, as this will have an impact on support being obtained. To explore this connection researchers have examined the relationship between dependency and inter-personal sensitivity in both laboratory and field settings and have consistently found across different participant groups that dependent individuals seek help far more frequently than non-dependent individuals. Diener (1967) and Sinha and Pandey (1972) both found that male American and Indian undergraduates who had scored highly on a

dependency scale exhibited more help seeking behaviour when undertaking problem solving tasks than low scorers. Sroufe et al. (1983) also had similar findings with nursery and primary school children using a mixed gender sample. Shilkret and Masling (1981) addressed directly the impact of both participant and experimenter gender and found that the gender of the person from whom help is sought is influential, with dependent males asking for more help than other males regardless of the gender of the researcher but dependent females only asking for more help only from a female experimenter. These findings suggest the presence of help seeking behaviour may influence whether therapeutic help is sought in the first place and even the gender of therapist chosen but since in all cases the potential helper was an authority figure it is not clear whether similar behaviour would have been exhibited if the helper had been a peer.

The research indicates that dependency is associated with inter-personal sensitivity in both children and adults and, with the exception of the findings of Juni and Semel (1982) the relationship between dependency and inter-personal sensitivity is stronger in men than in women. These conclusions are supported by Masling, O'Neil and Katkin (1982), who found no changes in electro-dermal responses of non-independent participants measured before during and after an encounter with a cold unyielding and a warm friendly individual, but found dependent participants showed a significant increase in electro-dermal activity during similar encounters. Masling, Johnson and Saturansky (1974) found in both an initial and a follow up study that dependent male but not females were significantly more accurate in

their inferences about the attitudes and beliefs of their room-mates than non-dependent individuals, suggesting that dependent individuals can more accurately perceive social behaviour in others.

The research into affiliation has not directly measured the need for affiliation but has instead looked at the relationship between dependency and affiliation. Masling, Price, Goldberg and Katkin (1981) measured electro-dermal responses in two conditions and found that individuals who had high dependency scores using an established measure showed greater arousal when left alone for forty minutes than when with another individual, whereas low scorers showed no change in levels of arousal. These findings were supported by Keinan and Hobfoll (1989) measuring anxiety levels of dependent and non-dependent pregnant Israeli women. Using self report measures twelve hours post delivery they found that dependent women were significantly more anxious when their husbands had been absent during delivery than if present. The anxiety levels of the non-dependent women were the same whether their husband was present or absent. In an attempt to measure the need for affiliation research has been conducted on the need for physical touching. Juni, Masling and Brannon (1979) found support for their hypothesis that an individual's need to affiliate would result in an increased willingness to touch another person. In an experiment where dependent and non-dependent individuals guided blind-folded same and opposite sex confederates through a maze, a significant positive correlation was found between dependency scores and the amount of time spent touching the confederate. Also dependent individuals

touched the confederates more often than non-dependent participants. It has also been found that dependent individuals expressed a greater desire for physical contact with romantic partners (Hollender, Luborsky and Harvey, 1970) and similarly Sroufe et al. (1983) found that dependent primary school children sought physical contact with their teachers more often than non-dependent children.

Dependency, evaluation and performance anxiety

The demonstrable connection between dependency and help seeking behaviour raises the question of how dependent individuals might react if they are forced to operate alone or if they are being assessed by an authority figure. Whilst not directly relevant to the role of dependency in therapeutic relationships the research findings are mentioned briefly here for completeness. Support has been found for the hypothesis that dependent individuals suffer higher levels of performance anxiety than others (Ojha, 1972) and it was also found that their performance anxiety could be minimised by them being given feedback on their performance by the researcher (Juni, 1981).

The link between dependency and psychopathology

A theoretical link has been made between dependency and a number of psychological disorders including depression, schizophrenia, phobias and substance abuse. Whilst this link to psychopathology has been most explicit in the

psychoanalytic model (Fisher and Greenberg, 1997), social learning theorists have also regarded dependency as a risk factor for psychological disorders. Despite this relationship, significant research only exists into dependency, depression and alcoholism, the key findings from which are summarised below. Research into smoking and eating disorders has also shown similar links but given the nature of the research question this has not been included.

Dependency and depression

Significant positive correlations have been found in numerous studies supporting the link between dependency and depression (Klein, 1989; O'Neill and Bornstein, 1991; Robins, 1990). This relationship has been found to exist in non-clinical populations (Bornstein and Johnson, 1990; Robins 1990) and in psychiatric patients (Klein, Harding, Taylor and Dickinson, 1988). The relationship has also been found to be greater in men than in women (Klein, 1989). The magnitude of the relationship between dependency and depression has been found to be as high as .53 in a correlation between Beck Depression Inventory (BDI: Beck 1967) and dependency scores in psychiatric outpatients (Brown and Silberschatz, 1989) and 0.50 for inpatients (O'Neill and Bornstein, 1991) and as low as 0.19 in Neitzel and Harris' (1990) meta-analysis. Bornstein (1992) having conducted an extensive review, concluded that dependency scores typically account for between 10% and 20% of the variance in depression scores. Having established that a link between dependency and depression exists what is not clear is whether dependency pre-disposes an individual to depression, which has been suggested by O'Neill &

Bornstein (1991) or whether dependency is a product of depression or they are both the product of some underlying variable. Blatt and Zuroff (2005) posit that individuals who possess high levels of self-criticism and/or dependency are vulnerable to developing depression following negative events. A recent study by Adams, Abela, Auerbach and Skitch (2009) tested this theory where a sample of 49 children ages 7 to 14 completed measures of dependency, self-criticism, and depressive symptoms. Subsequently, participants completed measures of depressive symptoms and negative events at randomly selected times over 2 months. Results indicated that higher levels of both self-criticism and dependency were associated with greater elevations in depressive symptoms, further supporting the proposition that dependency and self-criticism represent vulnerability factors for depression in young people. The implications of this research was not something that was specifically factored into the research interview questions since the researcher was interested in how Counselling Psychologists conceptualised and experienced dependency rather than trying gather any evidence on links to particular diagnosis.

Dependency and alcoholism

Classical psychoanalytic theory suggests the link between alcohol and dependency is based on a reliance on oral activity (smoking, drinking and eating) in order to cope with stress (Bertrand and Masling, 1969). In support of this is that dependent individuals obtain similar scores on a number of personality measures and also that they achieve low scores on measures of ego strength (Nacev, 1980) and self-esteem

(Ederer, 1988) which are also associated with increased risk of alcohol dependence. Whilst numerous studies have confirmed the relationship between alcoholism and dependency, what has not been tested is whether it predicts alcoholism or is caused by alcoholism, which may in turn cause an increase in dependent behaviours. Three of the participants in this study worked in an NHS Drugs and Alcohol service and they reported what they perceived as a connection between their clients and dependent behaviours. They regarded it as part of their work to accept that clients often transferred their dependence on alcohol or drugs to their therapist and this was seen to be a particular risk where attendance at the service was conditional on abstinence.

Dependency and use of health services

Dependent individuals have been found to use health services, including mental health, more frequently than other individuals. In one study it was found that dependent individuals, who were measured on two dimensions, were prescribed psychotropic medication at nearly 50% higher rates than other patients and received twice as many consultations for medical services (O'Neill & Bornstein, 1991). This conclusion is consistent with other research where dependent college students were found to make a greater number of visits to the health centre (Bornstein, 1993) and dependent nursing home residents who needed a greater number of emergency consultations (Emery and Leshner, 1982). There is also evidence to suggest that psychiatric dependent patients will have difficulty

terminating in-patient treatment as it will be seen as relinquishing their caregiver.

Greenberg & Bornstein (1989) have also found that dependent psychiatric in-patients remained in hospital for longer when compared to non-dependent individuals with similar diagnoses and similar findings have been reported for cardiac patients (Brown and Rawlinson, 1975). The link between duration of treatment and dependency has been found to be weaker in an out-patient setting but even then the link still exists (Snyder, 1963).

A further connection has been found between dependency and the frequency of use of health services, which may be relevant to individuals seeking therapy (Greenberg & Bornstein, 1989) in that dependent individuals consulted medical practitioners more quickly than other individuals when symptoms arose. An explanation consistent with dependency behaviours may be that they are more willing to surrender their care to a knowledgeable caregiver. In support of this Greenberg and Fisher (1977) found that dependent individuals give more positive descriptions of a typical physician, viewing them as warmer, more pleasant than others and also perceiving a stay in hospital as more pleasant and less stressful than others.

The literature indicates that high levels of dependency are associated with compliant behaviour, particularly around authoritative figures (Bornstein & Bowen, 1995) and this link is strongly supported particularly in medical and psychiatric

settings. Studies on compliance with psychotherapeutic regimes show dependent patients being regarded as more cooperative and compliant by medical staff. In one of the first controlled studies Nacev (1980) examined the relationship between dependency and compliance in a mixed gender group of adult out-patients and found a negative correlation between dependent scores and the number of missed therapy sessions. A similar study by Poldrugo and Forti (1988) using a sample of 717 male out-patients being treated for alcoholism also provided methodologically sound evidence for the link between dependency and compliance with treatment. They found that 75% of their participants with a diagnosis of dependent personality disorder attended group therapy for 1 year compared to only 33% of patient with other diagnoses. Similar results were also found by McMahon, Kelley and Kouzekanani (1993) with a group of men undergoing residential treatment for substance abuse.

Dependency and the impact of client behaviour on therapy

Client characteristics are considered to be an important component of the therapeutic relationship, including the client's expectations of being helped, their ability to trust others and their history of relationships (Gilbert and Leahy, 2007). This can be illustrated by an examination of Bornstein's (1993) Cognitive/Interactionist model of inter-personal dependency in which he explicitly links dependency related traits with health related behaviours. His model suggests that cognitive structures (self and object representations) formed early on influence motivations, behaviours and affective responses which lead to the seeking of

guidance, protection and support from others. Also a self-representation in which one is seen as powerless and ineffectual will manifest itself in affective responses such as a fear of abandonment or a fear of negative evaluation. In further research Bornstein (2006) identified what he referred to as 'the helpless self-schema' which when activated in a dependent person sees the self as helpless and weak. These dependent behaviours and responses will play a key role in all relationships, including with the therapist, and may also impact therapeutic outcome. In particular fear of abandonment may lead to difficulties in terminating therapy and separating from the protection of the therapist. In support of this Greenberg & Bornstein (1989) found that dependent psychiatric inpatients remained in hospital significantly longer than non-dependent patients with similar backgrounds and diagnoses.

Dependency and therapeutic outcome

As dependency is associated with compliance and cooperation it may be unsurprising to find that high levels of dependency are associated with enhanced treatment outcome, with dependent psychiatric patients showing greater functioning than other patients following both out-patient and inpatient therapy and also showing lower recidivism rates over both short (12 month) and long term follow up (8 years). Fals-Stewart (1992) actually found that recidivism rates were as much as 50% less for dependent psychiatric patients undergoing treatment for substance abuse. Further research has shown that positive treatment outcome may depend on the type of treatment being provided with Blatt (1992) finding that

dependent psychiatric inpatients showed more positive outcomes when engaging in insight orientated therapy, which allows for much greater interchange between therapist and client than classical psychoanalysis. Similar findings were made by Blatt and Ford (1994) where self reported positive outcome by dependent patients focused on improvements in their relationships whereas for non-dependent patients any improvement related to increases in self esteem.

Dependency and therapeutic orientation

The aim of the research was to investigate how participant Counselling Psychologists, who adopt a relational focus and take a pluralistic approach in their work and accordingly may be less wedded to a particular theoretical orientation, experience the phenomenon of client dependency. Counselling psychology, which has a strong connection with American humanistic and existential psychology being committed to establishing the value of psychology in therapy, established itself as a separate profession in the United Kingdom in 1994. These psychological influences comprise phenomenology (including humanistic and existential thinking), psychodynamic and cognitive behavioural traditions (Woolfe, Dryden and Strawbridge, 2003). Accordingly, having some understanding of how different theoretical orientations regard dependency is likely to aid greater understanding of how it is experienced by the counselling psychologist participants, who were likely to have different theoretical preferences. Much of the research examined above has focused on the behaviours of clients with dependent personality traits and how

they are predisposed to behave in particular environments. However, the theoretical approach used by a therapist is also likely to affect these behaviours.

Given the origins of dependency in psychoanalysis it would be surprising if its role in psychodynamic therapy was not recognised as relevant. Freud (1913c) himself said he saw as the central aim of analysis 'to attach him [the patient] to it [the treatment] and to the person of the doctor' (p.139). Psychodynamic counselling recognises the role of dependency in therapy in relation to transference, where the client frequently re-enacts aspects of their past relationships with their therapist (Jacobs, 2004). However, it is acknowledged that, where dependency exists in therapeutic relationships, there is a danger that some clients will 'swallow whole what their counsellor says' (Jacobs, 1985 p. 58) with the consequence that the client may be prevented from developing their own identity. Winnicott (1965), with his developmental influence, regarded dependency in infants as inevitable but recognised that from that state of dependence growth towards independence could occur but only where a sensitive adaptation was made to the infant's dependency needs. Tait (1997) in her research into whether dependence was a means or an impediment to growth found that clients believed long term therapy potentially fostered an unhealthy dependency.

Goldfarb (1969) found that client dependency can be used to therapeutic advantage provided the therapist does not interfere with a dependent transference

but discourages the client's dependent behaviours as therapy progresses. Blatt (1992) agreed that dependency related issues were central to a full understanding of transference and counter-transference, but was concerned that the therapeutic progress of some clients could be impeded where a negative counter transference on the part of the therapist results in the therapist feeling powerless (Bornstein, 2005). Therapist's counter-transference to dependent clients does not feature in the literature although Winnicott (1949) identified the existence of difficult feelings towards clients, regarding it as important for therapists to 'not deny that hate really exists' (Winnicott, 1949 p.70) because denial would lead to 'therapy that is adapted to the needs of the therapist rather than the patient' (Winnicott, 1949 p.74). Subsequently research into this area has been largely neglected, although Tait (1997), when looking at the impact of client dependency on those in helping roles, found it was the source of much discomfort, with participants describing feeling 'scared' 'smothered' and 'manipulated' by dependent clients (Tait, 1997, p. 22). Therapist fear is also something that has been explored in the literature but frequently this focuses on physical rather than psychological fear (Pope, Spiegel and Tabachnick, 1986).

Counselling psychology seeks to engage with subjectivity and inter-subjectivity, values and feelings (British Psychological Society (BPS), 2000). 'At the heart of this philosophy is a belief that the therapeutic relationship involves working towards an authentic meeting of equals and has the intention of enhancing self-determination and fulfilment of potential' (Woolfe et al. 2003, p.11). Given the influence on

counselling psychology of humanistic thinking in which the individual is seen as self-conscious and reflective, with the capacity for choice and personal responsibility, an examination of the approach to client dependency taken by Carl Rogers is relevant. In person centred therapy (Rogers, 1951) the emphasis is on the therapist and client meeting as equals with the objective of therapeutic work being to facilitate self-actualisation and the client's ability to take responsibility. The therapeutic relationship is seen as supportive but not supporting (Rogers, 1951). This is accompanied by the belief that even if it might seem caring to facilitate dependency for a vulnerable client it is difficult to wean them once the dependency has been created (Mearns and Thorne, 2007).

When writing about the central concept of transference in psychodynamic work, which is not actively recognised in person centred counselling, Rogers (1951) noted that in general he found the attitude of clients to their counsellor was mild and real rather than being of a strong, affective transference nature and that in his experience clients were unlikely to leave counselling with a dependency on their therapist. He did, however, recognise that on occasion 'there may be a desire for dependence upon the counsellor, accompanied by deep affect' (Rogers, 1951, p.200). Whilst he acknowledged that all therapists, irrespective of orientation, were likely to encounter such desires for dependency, it is how they were worked with when they were met that was important. In psychoanalysis a relationship develops based on these attitudes, which is then central to the therapeutic process, whereas in person centred work 'this involved and persistent dependent transference

relationship does not tend to develop' (Rogers, 1951, p. 201). Instead for Rogers it was the 'impersonal' and 'secure' nature of the therapeutic relationship that was the vital foundation for therapeutic work. He believed that for effective brief therapy it was important that a transference relationship did not develop as resolution was often slow and difficult, thereby necessitating longer term work. This concern is echoed by Smith (2003) noting that regression to dependency has a place in longer-term therapies but that it becomes problematic in short-term work. In recognition of this problem regression and transference neurosis is to be discouraged in brief dynamic therapy, instead transference responses are worked through as soon as they appear in order to minimise their impact (Molnos, 1995). Coren (2001) suggests that the nature of the relationship in brief dynamic therapy should be collaborative and companionable, with the therapist adopting an 'oblique third-party role' (p.109), which is akin to the 'impersonal' and 'secure' relationship suggested as important by Rogers (1951).

Rogers (1951) believed that if the therapist avoided any evaluation of the client the establishment of a dependent transference relationship was discouraged. In this context he saw evaluation as constituting judgement and as comprising such things as direction, reassurance, criticism and praise. He also believed that the therapist's expectation of dependency played a part in whether it arose or not. His stance that everything a client has to say at the moment it is said be regarded as 'a responsible expression of the self as it exists at the time' (Rogers, 1951 p. 215) is seen as encouraging independence. Alternatively where a therapist is regarded as an expert

by the client the expectation can be set up for control to be handed over by the client to the therapist with the result that dependency ensues. In psychodynamic therapy, where the analyst attempts to interpret and evaluate the attitudes and behaviour of the client, the therapist occupies the powerful position of an expert, who understands the client better than he does himself, with the result that the client then comes to rely on the therapist and his expertise. Alternatively, in person centred therapy the focus is on the client retaining ownership of his attitudes and behaviours and with this greater autonomy.

Given the commitment of counselling psychology in establishing the value of cognitive behavioural traditions (Woolfe et al. 2003) an over view of the role of the therapeutic relationship in cognitive behavioural approaches as the context for dependency is included here. Historically the role of the therapeutic relationship in cognitive behavioural approaches has received less focus but this is principally because it has been regarded as important but not sufficient on its own for therapeutic change (Beck, 1967). The emphasis is on the therapist needing to possess both relational and technical skills in order to promote client behavioural change. Ellis (1979) was sensitive to how therapist behaviour could foster dependency, arguing that it was not appropriate to be particularly warm towards clients because this may reinforce a client's dependency and be counter-productive for the client in the long term but no particular theoretical stance has been taken on dependency in cognitive behavioural therapy (CBT). It could be argued that given the emphasis on therapist relational and technical skills, dependency could

manifest itself in either a psychological or a practical context where the client needs the therapist to help them with home work exercises commonly used in CBT. This has been recognised in personal construct therapy where dependency is regarded as useful at certain times but at others as preventing clients from conducting useful behavioural experiments outside of the therapeutic environment (Roth & Fonagy, 2006).

Object relations therapy can be seen as an approach which recognises dependency in that it specifically encourages independence and the development by the client of a more autonomous self rather than dependence of any kind. In so doing this approach recognises that within a safe and caring therapeutic relationship it is possible to foster trust and intimacy and at the same time still possible to encourage autonomy rather than fostering dependency (Roth and Fonagy, 2006).

Dependency and its impact on the therapist

Where a client exhibits dependent behaviour this will have an impact on how a therapist experiences them and it is this experience that is at the heart of what is explored in this research. As can be seen from the literature reviewed, if an individual has dependent personality traits their need for nurture, guidance and support is likely to have both positive and negative influences on how their therapist experiences them. The literature indicates that dependency is associated with positive feelings about influential individuals, which is likely to have an impact

on transference and counter-transference if a psychodynamic approach is being used. Dependent clients are also likely to have a strong desire to please their therapist (Bornstein 1994) and also go to great lengths to avoid negative evaluation by those in authority. They have also been found to develop strong transference reactions to their therapist early on in the therapeutic encounter, which can help them tolerate setbacks. The overt expression of dependent behaviours can result in negative counter-transference reactions for the therapist. Specifically, strong inflexible dependency can be over whelming, eliciting feelings of powerlessness and frustration. A therapist, who is unable to tolerate strong needs for intimacy, may start to engage in behaviours that allow them to distance themselves from the client, which could in turn undermine the positive transference (Gilbert, 1987). The literature indicates that dependent clients may also find it difficult to leave therapy, which can lead to dependency behaviour being activated where an ending is contemplated, with the possibility of clients contacting their therapist out of hours, arriving early and/or not wanting to leave sessions or asking for more time.

Dependency in the context of the therapeutic relationship

Irrespective of the therapeutic model used the quality of the relationship between therapist and client has been found to be more important in therapeutic change than the techniques used by therapists (Rogers (1967). In a meta-analysis of more than 1000 studies (Orlinsky, Grawe and Parks, 1994) the power of the therapeutic relationship was highlighted, with the quality of client participation, the therapeutic bond, the therapist's contribution and the use of skilful interventions being key

factors that influenced the quality of that relationship. The Counselling Psychologists interviewed regarded the relational aspects of therapy as central to outcome, which has at its heart the philosophy that therapeutic relationships involve working towards an authentic meeting of equals with the intention of enhancing self-determination and the fulfilment of the potential of the client (BPS, 2000).

In their qualitative research on significant moments in therapy Levitt, Butler and Hill (2006) found that 21 out of 26 participants felt their relationship with their therapist was a central part of therapy and that an increasing dependence on the therapist at the initial stages of therapy allowed the client to individuate from significant others, tapering off as the client became more self-reliant. To be balanced against this is the additional finding that, whilst a caring relationship is essential for therapeutic work it can become dangerous when it oversteps the client's agency and confers dependence on the client (Levitt et al. 2006).

Feeney (2007) advanced the position that relationships are critical in human lives and that everyone needs to be able to depend on specific others in certain circumstances to be an optimally functioning person. He found, when investigating dependency in close relationships, that the acceptance of dependence ultimately promoted autonomous functioning and that autonomy and relatedness were both innate psychological needs. Dollard and Miller (1950) noted that therapy was often

facilitated by initial client dependency and asserted that clients brought a desire to please the therapist when coming to therapy, which they considered to be one of the main forces helping the client overcome any initial anxiety associated with therapy. They hypothesised that as therapy progresses the client finds other motivations for continuing with therapy and with this their independence grows.

Heller & Goldstein (1961) examined the extent to which client dependency and therapist expectation of client improvement were relationship maintaining variables. They found support for the notion that initial client dependence can act in ways that maintain the early stages of the therapeutic relationship. Winder, Ahmad, Bandura and Rau Lucy (1962) and Caracena (1965) used a qualitative methodology to study dependency within the client therapist interaction during the initial stages of therapy and found that the client's willingness to discuss dependency issues depended on whether therapists mentioned content relevant to dependency. Schuldt (1966), using a quantitative methodology, found this applied to all stages of therapy, although clients were found to initiate more dependency responses early on. Caracena (1965) found that the more experienced a therapist was, the more likely they were to raise issues of dependency with clients.

If the therapeutic relationship is seen as a co-creation of client and therapist it is likely to follow that the nature and experience of dependency will differ depending on from whose perspective it is viewed. During the research interviews a

participant related how she had become dependent on her own therapist during long term psychoanalysis, which provided a different perspective. Several participants also mentioned therapist dependency on the client and mutual dependency in their relationships with clients. (Tait, 1997) found that a therapist's dependence on a client can be educational, practical, financial or emotional.

Gender and Cultural and perspectives on dependency

Gender differences in dependency characteristics have been found where self-report measures have been used, which reduce when projective tests are used (Stiver, 1994). Also gender differences are not been found in young children (Maccoby and Jacklin, 1974) but higher levels of dependency are found in girls by the time they reach school age (Kagan and Moss, 1960). Kagan & Moss (1960) have argued that traditional sex roles in Western cultures put sanctions on dependent behaviour in men with no corresponding negative sanctions for women, who display dependent behaviours. Studies on stereotypes about the ideal masculine figure have shown that the most positively evaluated male traits are dominance and aggression (Block 1973). This apparent gender related change in levels of dependency with age may be a result of cultural and social factors, which serve to encourage the expression of dependency needs in women but discourage their expression in men (Bornstein, 1992). The participants interviewed for this research regarded gender to be irrelevant in their evaluation of dependency in their clients, reporting no gender related difference. In contrast to Eastern cultures, where dependency is seen as a sign of strength and something to be encouraged, in

western cultures, with its individualistic emphasis, dependency in adults is associated with weakness, indecision and helplessness (Tait, 1997) whereas independence is highly valued being associated with strength, individualism and leadership (Woolfe et al. 2003).

Methodologies employed in research on dependency

Except for Winder et al. (1962) and Caracena (1965), who used a qualitative methodology to study dependency within client therapist interactions, much of the research on dependency has used a quantitative methodology and there may be a number of reasons for this. When the research referenced above was being conducted in the 1960's qualitative research methods were not regarded as particularly suitable for testing psychological theory or adding to the psychological knowledge base, with the result they were little used. Traditionally psychology research was based in positivist epistemology and was therefore concerned with establishing objective methods of investigation that are not possible with qualitative methodologies (Madil, Jordan and Shirley, 2000). Qualitative research has its origins in the social sciences, aiming to gather an in-depth understanding of human behaviour and consequently it became a popular methodology for social psychology research during the 1980's. Today a range of post-positivist epistemologies are used which recognise the role of interpretation and metaphor in the production of social scientific research findings. Much of the research reviewed was conducted in the context of the health service, where evidence of effectiveness

of treatment was sought to support continued funding by government bodies or insurance companies. In this context research using quantitative methods was regarded as better quality evidence of effectiveness of treatment since control trials could be used, which may explain the continued absence of qualitative research.

Tait (1997) used a qualitative methodology in her exploratory study investigating how professionals engaged in therapeutic relationships viewed dependency in their clients, using focus groups to collect data. She believed dependency was likely to be an issue for all professionals whose work involved a counselling element and wanted to investigate whether her participants regarded dependency as a means or an impediment to growth. Tait (1997) concluded that there was 'considerable concern' amongst her sample of counsellors, teachers, nurses, and social workers about 'issues of dependency, and a need for more rigorous research into the management of client dependency' (ibid p.17) which acted as a spring board for this research. She found five main themes which can be summarised as follows. (i) 'The nature of dependency' which her participants described as 'the need for support' and a desire to be 'told what to do' in order to avoid taking responsibility; (ii) 'views of dependency in clients' where her participants agreed that independence comes from dependence in the sense that 'independence is something that is achieved out of dependence' (Winnicott, 1965, p.5) and cannot take place unless the infant's needs are properly tended to. In this connection her participants also questioned whether dependency in therapeutic relationships was legitimate, acknowledging

that it was a cause of much discomfort for counsellors with such feelings as being 'scared', 'smothered', 'manipulated' and doubt of their ability to be 'good enough' being identified (Tait, 1997, p.22). (iii) 'Boundary issues' and in particular the maintenance of boundaries in order to mediate against dependency, which was consistent with the researcher's findings. (iv) The 'counsellor's awareness of dependency', which related to the need for counsellors to be aware of the power invested in them by clients and the consequent influence they wield which was identified by all of the participants interviewed for this research. (v) Tait's final theme related to 'dependency in the counsellor', which centred round feelings of loss and responsibility when clients ended therapy and the counsellors need to make things better for clients, which was not something identified by any of the participants in this research. Tait's (1997) findings acted as the inspiration for this research and also helped to inform some of the prompt questions used in the research interviews. There has been no research into dependency in the context of counselling psychology, although Tait's participants were a diverse range of professionals including social workers, teachers, nurses and educational psychologists, all of whom had a counselling aspect to their work. Other research into dependency has been limited to the context of psychotherapy (Heller & Goldstein, (1961); Winder et al, (1962); Caracena, (1965); Bordin, (1979); Schuldt, (1966); Bornstein, (2005)).

Given the scope of this research project it has been necessary to focus in on particular elements of existing literature and also to limit the inclusion of other

elements. The researcher believes that this has been done in a manner that is sensitive to the research topic. In particular since the research is concerned with counselling psychologist's perception, understanding and experience of dependency in their client work, the literature included has in the main focused on the concept of dependency in the theoretical context of psychodynamic, humanistic and cognitive behavioural approaches, which have informed counselling psychology. The literature review has also included an extensive review of the theoretical underpinnings of the term dependency with the aim of providing an understanding of the concept under examination.

CHAPTER 3

METHODOLOGY

Introduction

With the exception of Tait (1997), research into dependency has to date principally been conducted using quantitative research methods in the context of psychotherapy to study the relationship between dependent personality characteristics and other behaviours. As studies using qualitative methods can usefully supplement quantitative analysis by aiding exploration of therapeutic practice rather than merely outcome (Brocki and Wearden, 2006) the researcher believes using a qualitative method to explore the phenomenon of dependency in therapy is apposite. Using a qualitative approach to explore an aspect of the therapeutic relationship is also supported by McLeod (2001, p.16), who suggests that the 'activity of doing qualitative research (identifying and clarifying meaning; learning how the meaning of aspects of the social world is constructed) is highly concordant with the activity of doing therapy (making new meaning, gaining insight and understanding, learning how personal meanings have been constructed)'. The Researcher believes that by choosing to use IPA (Smith, 1996), which is regarded as a suitable methodology for exploring 'flexibly and in detail, an area of concern' (Smith and Osborn, 2003 p.53), a detailed in-depth analysis of Counselling Psychologists' lived experience of dependency has been obtained. This has produced novel information about the phenomenon of dependency in a

therapeutic context, which enriches current literature and may generate additional theoretical insight into the impact of dependency in counselling psychology and psychotherapy.

Epistemological issues

The purpose of research is to answer a question or to provide some insight about the subject under investigation. In that sense its purpose is to add to knowledge.

That begs the question; what is knowledge? Epistemology is a branch of philosophy that relates to the theory of knowledge - what it is possible to know and how such knowledge can be obtained. Research methods provide a way to answer research questions and as such have been described by Kvale 1996a: p. 278 as 'the way to the goal'.

Positivists believe that there is a straightforward relationship between the world (objects, events, phenomena) and our perception and understanding of it. They believe reality can be studied and understood by measuring causal relationships between variables (Denzin and Lincoln, 2000) and that it is possible to describe what is 'out there' and to get it right (Willig, 2001). This implies that the goal of research is to produce objective knowledge without personal involvement or vested interests on the part of the researcher. Qualitative methodologies focus on meaning - how do people make sense of the world and how do they experience it? Researchers who choose to use qualitative methodologies have no interest in

preconceived variables or cause and effect relationships and they do not aim to predict. Instead they aim to insightfully describe a phenomenon and add meaning.

From an epistemological standpoint the researcher does not believe that knowledge can be objectively measured. Instead believing that in the context of research knowledge is obtained by the analysis of information obtained from individuals. Information can be obtained in a number of ways; by experimentation, by observation, or by direct and indirect questions, in writing or verbally. Whatever method is chosen to obtain raw data from research participants, these participants exist in the context of their social world and have their own opinions and views, shaped by their experience of being in that world. In that sense it is difficult to see how any information obtained can be objective. Added to this is the impact of the researcher on the information obtained. Firstly, in terms of their role in data gathering; the questions they ask, the way they ask them and their reaction to the answers given will all have an impact on the data they collect. Secondly, 'the analytic process cannot ever achieve a genuinely first person account – the account is always constructed by participant and researcher' (Larkin, Watts and Clifton, 2006, p. 104). As it is impossible to ignore the impact of the researcher on what is found, a key area of debate in qualitative research is the extent to which any method can really provide access to the personal world of the research participant. All the researcher can do is acknowledge the difficulty of escaping their own preconceptions and do a sensitive and responsible job. Whilst recognising the difficulty of escaping from the preconceptions of our world (Larkin et al, 2006),

these difficulties should not prevent a researcher from endeavouring to reveal the subject matter of their research on 'its own terms' (Larkin et al. 2006, p. 108).

Whilst acknowledging the difficulties outlined above, a qualitative research strategy was chosen by the researcher because it facilitates access to participants' views, perceptions, reactions, attitudes, opinions, thoughts, and experiences allowing 'patterns and meaning to emerge' (Smith 2008, p.246). It facilitates deeper insight into the views and experiences of participants by enabling a more in-depth examination than might be obtained through positivistic empirical methods. By choosing to use a qualitative method, which focuses on how social experience is created and given meaning, the researcher has attempted to understand the participants' experience in depth and to make sense of the phenomenon of dependency in terms of the meanings they bring to the concept (Denzin & Lincoln, 2000).

IPA as a qualitative methodology

As there are a number of methodological tools used in psychological inquiry, in order to justify using IPA, the researcher will examine its key features and the reasons for employing the method in preference to other approaches.

IPA was developed by Smith (1996) 'to allow the rigorous exploration of idiographic subjective experiences and, more specifically, social cognitions' (Biggerstaff and Thompson, 2008, p.215). In order to provide an understanding of being in the world, IPA enables the exploration of personal experience through the emergence of meaning through interaction between researcher and participant. It 'aims to explore in detail participants' personal lived experience and how participants make sense of that experience.' (Smith, 2004, p.40) IPA is 'phenomenological in the sense that it is concerned with exploring experience in its own terms' (Smith, et al. 2009, p.1). It regards individuals as self-interpreting beings, who influence and are influenced by their world and, as this occurs, they assign subjective meaning to events that occur. IPA is interpretive rather than the purely descriptive and recognises the central role of the researcher in making sense of the participant's personal experience. In so doing they can be said to be engaged in 'a double hermeneutic' (Smith, 2004, p.40) in that the researcher tries to make sense of the participant trying to make sense of their personal and social world. Given the central role of the researcher in the research process, to deny the extent of this influence, as do some qualitative methodologies, would be to deny reality.

IPA has been influenced by three main areas of philosophy, which inform its suitability for the examination of the phenomenon of dependency in a therapeutic context, which are examined below.

Phenomenology

IPA's first philosophical area of influence is phenomenology, which has at its heart an interest in the experience of being human. It is thought that such an examination can produce 'a rich source of ideas about how to examine and comprehend lived experience' (Smith et al. 2009, p.11). Obtaining knowledge of an individual's experience so as to identify the essential qualities of that experience is of fundamental importance. This requires research participants to be reflective about their experiences. Heidegger (1927) introduced into phenomenology the concept of 'dasein', which relates to the unique quality of being human, being concerned with the practical activities and relationships that human beings are involved in (Smith et al., 2009). This 'shared, overlapping and relational nature of our engagement in the world' (Smith et al. 2009, p.17) is referred to as inter-subjectivity. Dependency is inter-subjective in nature, only arising in relation to another. This acknowledgement of the influence of the relational seems to provide support for the researcher's use of IPA in the examination of the phenomenon of dependency in therapeutic relationships.

Hermeneutics

The researcher's attempt to gain understanding is necessarily interpretative and so it is important to acknowledge the influence of hermeneutics on the research process and to assess its potential impact. Hermeneutics has its roots in the analysis and interpretation of ancient texts and is concerned with whether it is possible to

uncover the intentions and meaning of another individual. To the extent this can be done, it is by a process of interpretation, which can be from a grammatical and psychological perspective. IPA enables the researcher to examine how their analysis offers meaningful insight, which goes beyond the explicit claims of the participants. This 'added value' (Smith et al, 2009, p.23), which can be described as the researcher bringing the unconscious experience of the participants to consciousness, is important in terms of bringing what is hidden into the light. This is likely to be important when examining a phenomenon like dependency, which is regarded negatively in the western culture of origin of participants and the culture in which they work as therapists.

Idiography

Whilst psychology tends to be nomothetic in nature, wanting to make claims for a particular population, IPA is based on an idiographic approach, which is concerned with particularity rather than the general. It is attempting to capture a particular experience of a particular set of participants and is not trying to substantiate more general claims. Unlike positivist approaches, which claim that reality can be studied, captured and understood, IPA sees reality as a social construction, which can be illuminated from the interpretation of participants' lived experience of being in the world. This was seen by Husserl as 'an essential precursor to any further scientific account' (Smith et al. 2009, p.15) suggesting it has an important role in a scientific context if not regarded as scientific in itself. It is, however, possible to move from the particular to the general in IPA but this tends to be done cautiously

because claims are grounded in a particular case. IPA also has the capacity for making links between the understandings of participants and theoretical frameworks in mainstream psychology.

IPA and sample size

Patton (2002) has argued that there are no rules for sample size in qualitative inquiry, which depends on: what you want to know; the purpose of the inquiry; what is at stake; what will be useful; what will have credibility and what can be done within the available time and resources. Smith et al. (2009, p.51) agrees 'there is no right answer to the question of sample size' it rather depends on the richness of the individual cases. The hermeneutic epistemology of IPA does not require data saturation. In this way IPA differs from other qualitative methodologies, such as grounded theory, which aims to continue collecting data until new themes no longer emerge and, once saturation point has been reached, attempts to establish claims for the wider population. In contrast, the sample size in IPA need only be large enough to illuminate the research question and to provide sufficient information to enable the development of an interesting interpretation (Brocki & Wearden, 2006). Morrow (2007) has argued that 12 participants should be sufficient provided the data collected from each are varied and extensive and tap experiences in depth. In contrast more recently Smith et al. (2009, p.51) observes that sample sizes are reducing because, given the focus on individual experience, 'the issue is quality, not quantity, and given the complexity of most human phenomena, IPA studies usually benefit from a concentrated focus on a small

number of cases.’ Smith et al. (2009) says that as a rough guide between 3 and 6 participants is appropriate for a student project using IPA in that this should enable the development of points of similarity and difference between cases but not be overwhelming in terms of the amount of data collected. The researcher was mindful of the warning Smith et al. (2009) that it is likely to be more difficult to be true to the IPA approach with a sample that is too big rather than too small, choosing to interview 8 participants, which was consistent with Carradice, Shankland and Beail (2002), who used a sample of 9 mental health nurses in their study of professional practice decisions. As the researcher was not investigating a general ‘truth’ or attempting to reach a consensus (Smith, 2004), a small sample is appropriate. What is important is the production of an account that is transparent in its systematic analytical description, regardless of how small the sample.

IPA and psychological research

IPA’s use in psychological research has been relatively short lived. It was initially used in health psychology, which has over the last fifteen years been developing as a field distinct to clinical psychology, but its use is not limited to that area of inquiry (Smith, 2004). More recently IPA has been used in social, clinical and counselling psychology research (Smith et al. 2009) with a number of papers being published (Knudson and Coyle, 2002; Rhodes and Jakes, 2000). A wide variety of topics have been researched using IPA but there are very few studies concerned with aspects of therapeutic intervention (Carradice et al. 2002; Golsworthy and Coyle, 2001) akin to the research conducted. IPA recognises the universal inclination of individuals

towards self-reflection (Schon, 1983). Its relevance as an epistemology particularly suited to Counselling Psychology research is demonstrated by its assumption that what people say about their lived experiences is connected to their underlying thoughts and meaning-making cognitions.

Data Collection and IPA

In contrast to some other qualitative research methods, IPA uses more flexible methods of collecting data such as semi-structured interviews, diaries and other forms of self-report, which enables a comprehensive description of the phenomenon being researched. This allows for novel and unexpected discussion from research participants and consciously avoids approaching a research project with preconceived hypotheses. This enables the researcher to discover potentially novel concepts, which are determined by the data gathered rather than from any previously developed theory. Broad research questions are used in order to allow unexpected avenues to emerge: 'the most exhilarating analysis is that often which develops unanticipated' and whilst it is the 'inductive position that is at the foreground for IPA' (Smith 2004, p. 43) Smith recognises that in reality the research process does contain both elements of induction and deduction. Brocki & Wearden (2006, p.92) recognised that what 'is important is to maintain flexibility and come to the analysis without pre-conceived ideas.' IPA also seeks 'to make a contribution to psychology through interrogating or illuminating existing research' (Smith 2004, p. 43). Therefore, findings do not exist in isolation, but should be related to, and compared with previous literature in the area being researched. According to Reid

et al. (2005), it is the ability of findings from IPA to relate to other forms of knowing (particularly mainstream psychology) that goes some way to explaining why the approach has become so popular in the field of psychology.

Data Analysis

The researcher's role in the data analysis involves an intimate familiarisation with the data collected and using an iterative process they endeavour to make successive and more organised attempts to make sense of the information gathered. This 'sense-making' activity will involve the development of general themes within which to organise the data and subsequently generate a set of more specific themes which mirror the nature of the participant experience and ultimately contribute to answering the research question (Shaw, 2004). In the context of the current research IPA should provide the type of comprehensive account from participants that will allow for a detailed and idiographic understanding of their lived-experience where clients become dependent on them during the course of their work as Counselling Psychologists.

Other qualitative approaches

In looking at other possible qualitative approaches, the researcher considered grounded theory, which is a model requiring the researcher to adopt a social constructionist position. It is regarded by Glaser and Strauss (1967) as a

methodology suitable for investigating a wide range of interpersonal processes and relations and as such may have been an appropriate methodology for the research conducted here. It produces a description of the phenomenon being studied but at its heart grounded theory allows for the development of theory 'grounded' in the observable experiences of research participants. It requires that research questions generate data to build a theoretical analysis (Charmaz, 2001) and it is possible for the data analyzed to generate theories that can explain behaviour. However, as the researcher was not so much concerned with the generation of theory but instead with the lived experience of the Counselling Psychologists, who encountered dependent clients in their practice, it was felt that grounded theory, which would produce a theory of therapeutic dependency, was not a suitable methodology.

Conclusion

IPA, in common with other qualitative methodologies which analyse interview generated data, has some limitations, relying on the ability of participants to put their experiences into words in a coherent manner. However, the researcher believed it to be the preferable method for the examination of the phenomenon of dependency in therapy because of its interpretive and not purely descriptive approach. IPA's declared aim of exploring the process through which participants make sense of their own experiences of dependency by looking in detail at their account of that experience (Chapman and Smith, 2002), justifies its use as an appropriate method for the research conducted. If what is sought from research is an exploration of participants' lived experience of the phenomenon under

investigation and the emergence of meaning through the interaction of researcher and participant, then IPA delivers this. If a universal truth is sought then IPA (or for that matter any other phenomenological methodology) cannot provide it.

METHOD

The research process

The research conducted was in partial fulfilment of the requirements for the degree of Psych. D at the University of Roehampton. The research process commenced with an application to the university's research degrees board on 23rd of March 2009. This was followed by an application for ethical approval made to the Ethics Committee of the School of Human and Life Sciences, which was approved on 1st of October 2009, with final approval from the University Ethics Board being received on 11th December 2009. Following the identification and selection of participants the first interview was conducted on the 11th of January 2010 and the final interview on the 21st of May 2010. Each interview was transcribed immediately following the interview, taking a day per transcript, and the analysis of interviews took place between June and August 2010. Following the University's process for the approval of examiners final submission of the thesis took place on the 16th of February 2011.

Counselling Psychologists as Participants

Counselling Psychologists were chosen as participants because the researcher's own discipline is counselling psychology and because their integration of psychological theory and research with therapeutic practice (BPS, 2008) made it less likely they would have firm theoretical views on the desirability or otherwise of dependency in therapeutic relationships. By selecting Counselling Psychologists, who work from a relational standpoint and who strive to become reflective practitioners, the researcher's expectation was that they would be able to fully express their experiences of dependency so as to provide sufficient information-rich data for the purpose of analysis (Morrow, 2005).

Heterogeneous Participants

The researcher recognises that whilst the number of participants chosen must be relative to the purposes and goals of the research it is necessary for there to be heterogeneity of participants to ensure the necessary focus on the research question. Accordingly, the target sample were registered BPS Chartered Counselling Psychologists living in the UK, who had been registered for 5 years or more and who were at the time of interview practicing as Counselling Psychologists in the NHS or had recently retired from the NHS. By using these selection criteria the researcher assumed participants would have the necessary theoretical understanding of dependency and, working from a relational standpoint, were also likely to have experience of the phenomena of dependency in their practice. As the BPS Division

of Counselling Psychology is only 12 years old, it was felt unnecessary to enforce an upper limit in terms of years of experience.

Identification and selection of Participants

The researcher used personal contacts to identify Counselling Psychologists working in the South West London Primary Care Trust, who the researcher then contacted by email or letter with a copy of an advertisement for participants (Appendix 1) asking if they would be willing to participate in the research and if so to provide certain information by email to the researcher to ensure they would meet the inclusion criteria. In addition the researcher contacted Counselling Psychologists listed in the BPS 'find a psychologist' section of the website using the email address listed, also attaching the advertisement and requesting information as aforesaid. The researcher also placed an advertisement for participants on the BPS website using the appropriate channels but no responses were received. If an individual contacted met the inclusion criteria they were contacted again by email to make arrangements for the researcher to interview them at a time and location convenient to them. This usually involved going to their place of work in the NHS but in the case of one participant the interview took place at her home and in another case at the researcher's home. The setting did not seem to influence the course of the interview although it is possible these two interviews may have had a more relaxed atmosphere, which may have aided disclosure. Prior to the interview participants were sent (by email in all cases) the participant briefing document (Appendix 2). This contained detailed information on the nature and purpose of the

research, the interview process, the expected duration of the interview, the right to withdraw at any time, details on how data would be treated and stored and how confidentiality and anonymity would be preserved. Those contacted, who agreed to participate, were asked to read and sign an original consent form brought to the interview by the researcher prior to the interview taking place. The researcher contacted 37 Counselling Psychologists through the means described above and from that number received 10 positive responses, 8 of whom met the inclusion criteria being at least 5 years qualified, and who were later interviewed.

Participant details

The 8 participants comprised 2 males and 6 females with ages ranging from 40 to 64. In addition to being qualified as Counselling Psychologists the participants had a number of other qualifications and used a variety of differing approaches in their work with clients, including psychodynamic counselling, person centred therapy, cognitive behavioural therapy and schema therapy. A list of their additional qualifications and the types of presentation they commonly work with is set out in table 2 in chapter 4. All participants were either working in the NHS at the time they were interviewed or had retired from the NHS within the 6 months prior to interview. Participants all had a minimum of 5 years experience working as Counselling Psychologists although the majority of the participants had experience of working in a counselling or helping role for far longer; details of which are set out in table 2 in chapter 4.

PROCEDURE

Interview Schedule

To gain an understanding from participants of the dynamics of dependency within the therapeutic relationship the researcher gathered data using semi-structured interviews which were structured so as to encourage a flexible collaborative approach in order to encourage the provision of in-depth data (Smith, Jarman and Osborn, 1999). This was done to give participants the maximum opportunity to guide the course of the interview by both elaborating on topics introduced by the researcher and entering novel areas where appropriate. Smith (1996) suggests that empowering the participants in this way also improves the probability of good rapport developing and tends to produce 'richer' data.

Interview Questions

The findings of Tait (1997) acted as the inspiration for this research and helped to inform some of the prompt questions used in the research interviews. Other questions were informed by other research findings. In particular, where participants felt they had no experience of clients becoming dependent the researcher asked about their experience of clients never missing sessions, trying to secure additional sessions, being reluctant to end therapy and contacting the therapist out of hours, which in most cases did elicit additional data. In order to avoid shaping the data collected into pre-conceived themes which could be criticised as being influenced by a post-positivist paradigm and as constructionist in

approach (Ponterotto, 2005) the researcher was careful to avoid including any questions which might have established such theme categories. Initial interview questions were reviewed and discussed with a Counselling Psychologist known to the researcher and agreed amendments made prior to conducting the first interview.

The interview consisted of open-ended questions, giving respondents space to express their views (Appendix 3) and commenced with an 'introducing question' to begin a conversation with the participant by soliciting rich, spontaneous descriptions of the phenomenon. Building from this 'follow-up questions' were used to extend answers given and to facilitate further exploration and elaboration. In addition 'probing questions' were used to seek deeper descriptions. Direct questions were used to introduce topics or dimensions and were also used after participants gave their spontaneous responses and indicated what they believed to be the central aspects of the phenomenon of dependency being explored. The researcher used interpreting questions to clarify meaning, understanding of content and participants interpretations (Kvale, 1996).

Interview process and data collection

Prior to the interviews being conducted participants completed a short questionnaire confirming the information they had previously provided by email as part of the participant selection process. Interviews were preceded by a briefing,

based on the participant briefing document (Appendix 2) and each participant signed the informed consent in Appendix 3. Participants were also reminded that their participation was voluntary, guaranteed anonymity, and told that they could withdraw at any time during or after the interview, whereupon their data would be deleted.

Prior to commencement of the interviews the researcher attempted to be as transparent as possible about the aims of the research (Burman, 1994) but details of the interview questions were withheld at this point so as not to reveal the central research question. During the interviews the researcher used the interview schedule as a guide in order to ensure that the interviews reached their intended depth and that relevant areas were not missed. During the interview, which was conversational in style, the researcher and participant interacted in a manner similar to counselling, with the researcher trying to use minimal encouragement, open-ended questions, and rephrasing as tools to help ensure as complete an understanding of the participants' perceptions and experience as possible (Kvale, 1996).

The interviews were conducted in person by the researcher between February and May 2010 and participants were interviewed at a time and location of their choosing, in a quiet room with comfortable seating. The researcher paid specific attention to establishing a 'trusting, open relationship with the participant and tried

to focus on the meaning of the participant's life experiences rather than on the accuracy of his or her recall' (Polkinghorne, 2005, p.142). Interviews lasted between 57 minutes and 1 hour 15 minutes and were digitally recorded to facilitate subsequent transcription, analysis, and interpretation.

Each interview was followed by a debriefing based on the contents of the participant debriefing document (Appendix 4). This allowed for discussion of any unresolved issues, provided opportunity for clarification, addressed any anxiety experienced during the interview process and provided the participant with a chance to provide feedback on the interview and research process (Kvale, 1996). After each interview the researcher wrote memos and reflective summaries of the process and content of each interview to inform the analysis and enhance reliability and validity of the research.

Interview follow-up

All participants were provided with a copy of the transcribed interview sent to a secure email address of their choice. This provided them with the opportunity of commenting on the content of the interview and of adding further reflections or removing any references they were unhappy with. Participants who had expressed an interest in receiving the initial themes were also provided with a draft which provided them with the opportunity of commenting on the themes that had emerged from the analysis and allowed the researcher to incorporate changes to

the analysis as appropriate. This was consistent with the recommendations of Smith (1996) and provided a measure of validity for the research.

Ethics

Prior to any contact with participants, following a rigorous process, which took over 8 months, approval for this research was obtained from the Ethics Committee at Roehampton University. Participants were guaranteed confidentiality and anonymity in the presentation of research results and to that end are referred to by number rather than name and any identifying details have been removed to protect their identity and maintain the confidentiality of personal data. All participants were briefed about the nature of the research and gave their informed consent for the use of interview data by signing the consent form in Appendix 2. By providing information about the research to the participants, ensuring participation was voluntary and allowing withdrawal at any time the researcher complied with the four key elements of informed consent suggested by Faden and Beauchamp (1986).

Data Analysis

Each interview was transcribed verbatim and the resulting transcripts formed the raw data for analysis using the method of IPA (Smith (1996, 1999)). The digitally recorded interviews were listened to carefully with the researcher paying particular attention to the participant's tone, pace, and inflexion. Note was made of any particularly resonant responses which might inform the subsequent process of

analysis. The transcripts were read and re-read to aid familiarisation with the data during which time the researcher underlined what appeared to be important responses and used the right-hand margin to annotate significant statements. The first stage of analysis involved coding the themes generated by the participants which required detailed, iterative reading of the transcripts and required the researcher to become intimate with the material over an extended period. This level of familiarity with the data ensured that the analysis phase of the research was informed and comprehensive. The researcher then used the left-hand hand margin to note initial emerging themes which were at this stage unstructured but provided a degree of cohesion around an identifiable concept. In order to achieve a fresh perspective, after a few days the process was repeated to allow confirmation of the initial themes and to enable new themes and observations to emerge. The researcher refined the themes and sub-themes, rejecting interpretations which were less well supported by the entirety of the data and refining those that emerged with greater resonance. On completion of this process provisional theme labels were devised, which were noted on the left-hand hand margin of the transcript. These themes were then listed on a separate sheet of paper in order to look for some order amongst the array of concepts and ideas and to extract master themes, which were re-checked to ensure they were represented in the verbatim transcript.

The analysis continued using the master themes list from the first interview to begin the analysis of the next transcript, searching for more instances of the

themes already identified from the first interview but also allowing for the identification of new themes as they arose. Where new themes emerged they were checked against the first transcript and where appropriate the previously elicited themes were modified or became master or sub-themes 'aiming to respect convergences and divergences in the data' (Smith and Osborn, 2003, p.73). This process continued in a cyclical fashion, adding new transcripts until all 8 had been exhaustively analysed. Where new themes emerged they were tested against all earlier transcripts.

The final stage was to produce a list of coherently ordered overarching categories and associated master themes annotated to indicate where each theme could be found in the transcript. Themes were not selected purely on the basis of prevalence in the data, other factors, including the richness of the passages which highlighted themes and also how one theme helped to illuminate other aspects of a participant's narrative, were also taken into account. Also certain idiosyncratic themes were rejected, for example the themes relating to the presenting problem and the role of supervision in James's transcript, as they neither fitted well into the structure of the master themes nor were particularly rich in evidence within the transcript. The resulting table of participants' consolidated master themes is presented as Appendix 5.

IPA Methodology and Researcher Perspective

IPA sees the researcher as an interpreter rather than just offering a descriptive account (Chamberlain, 2002). By explicitly recognising the interpretative nature of the approach it can be argued that researchers who choose to use IPA are under an obligation to address the issue of reflexivity. Whilst these issues affect all qualitative approaches to research IPA goes further in seeking to address these issues. Brocki & Wearden (2006, p. 92) suggest that 'it would perhaps represent best practice for researchers to present appropriate reflections on their role in the dynamic process of analysis where this might be argued to have had a significant impact on the final narrative account presented and in the course of the research itself.' Although the inclusion of verbatim extracts allows the reader access to the analytic process, the researcher believes that it is also necessary to acknowledge the preconceptions and beliefs that may have been activated during the research process. As such reflexivity can be argued to increase transparency and even augment the power of the data.

The researcher became interested in the phenomenon of dependency in therapeutic relationships because of hearing fellow counselling psychology trainees describe having powerful feelings for their therapists. This was further fuelled by the psychodynamic assertion that clients fall in love with their therapist because they repeat early patterns of relating previously experienced in relation to their parents (Grohol, 2009). This phenomenon described by Freud (1917) as transference is likely to arise in a therapeutic setting because of its intended safe,

nurturing and supporting qualities. This is to be contrasted with the researcher's own experience in therapy, where any feelings of dependency were initially completely absent and only apparent to a very minor degree even at the end of more than 3 years of therapy. This led to an interest in what influences feelings of dependency in therapeutic relationships and whether the presence or absence of dependent feelings has an impact on the quality of the relationship and more particularly how it is experienced by Counselling Psychologists. The researcher chose IPA to explore the phenomenon of dependency because it provided the opportunity for an in depth exploration of the nature of the experience of being with dependent clients.

The researcher's personal perspective on the phenomenon of dependency is likely to have been relevant to the outcome of the research to some degree and therefore, it may be useful at this juncture to advise that the researcher has herself strong views about inter-personal dependency; that it is both undesirable to be dependent and also difficult to be the object of another's dependency. Whilst the researcher made a conscious effort to consider the impact of these factors during data collection and analysis, by trying to be as transparent as possible she hopes to provide the reader with the opportunity to examine, observe and review any impact that her personal perspective may have had on the analysis conducted and the findings of the research.

Reliability and validity

There has been much discussion about how to assess the reliability and validity of qualitative research. Within the quantitative paradigm there is an attempt to screen out interpretation in order to produce a reliable representation of the research which can be replicated by following the experimental procedure. However, Tindall (1994) argues that the concept of reliability is not appropriate to qualitative research because whilst replication of a piece work is possible its use of different participants, researcher knowledge, and other constructivist processes will ensure the results bear little similarity. This suggests that the quantitative concept of reliability has questionable value within interpretative qualitative research.

Some general guidelines have been proffered by Yardley (2000) for assessing the quality of qualitative research, which are regarded by Smith et al, (2009) as taking a sophisticated and pluralistic stance. Her first principle is '*sensitivity to context*' where an important aspect of context is setting the research within current literature and ensuring that the research question seeks to fill gaps 'in current understanding rather than re-discovering what is already known' (Smith, 2008, p. 246). Sensitivity to the perspectives of the participants can be demonstrated by the researcher encouraging them to talk about what is important to them and not be constrained by the preoccupations of the researcher (Wilkinson, Joffe and Yardley, 2004). This can be further demonstrated by obtaining good quality interview data as a result of putting the participants at ease, showing empathy and negotiating the power differentials where researcher meets the practitioner (Smith et al, 2009). The

need for sensitivity continues into the analysis phase where the researcher must demonstrate a disciplined attention to the unfolding account of the participant from which they gain an understanding of their experience as they immerse themselves in the data. The researcher must not impose their own categories or meaning on to the data. Yardley's second principle of '*commitment and rigour*' can be demonstrated by researcher attentiveness to participants during the interview process and the care taken with the analysis. The researcher believes that the selection of homogeneous research participants, who have knowledge and experience to illuminate the research question, demonstrates a commitment to validity. By ensuring the analysis is conducted thoroughly and systematically, that it is of sufficient depth and breadth, interpretative rather than purely descriptive the researcher ensures that something is evident about the participants themselves and not just the themes they share. Commitment and rigour is also demonstrated by ensuring that emerging interpretations remain grounded in the experience of the participants through checking and re-checking against the original transcripts of the interviews. Thirdly '*coherence and transparency*' requires that the research makes sense as a consistent whole (Smith, 2008) and that each stage of the research process is thoroughly and accurately described in the writing up, which the researcher believes has been adequately demonstrated in this research report. The reader will have to judge whether Yardley's final principle of '*impact and importance*' has been fulfilled but the researcher believes the findings of this research contain something meaningful, interesting and useful, which has implications for both practitioners and policy makers.

Also relevant to validity is the need for the researcher to 'check out our interpretations with participants and treat their comments and understandings as an additional source of information and insight' Tindall (1994, p.145). Whilst the researcher was mindful of the need to check out their interpretations with participants only Sarah provided feedback on the themes circulated which enabled the researcher to take account of her comments in the analysis as appropriate.

Smith et al. (2009) regard independent audit of the researcher's analysis as a powerful way of testing validity and it has been suggested that research can only be valid if the researcher has the collaboration of others. In order to establish a different viewpoint and potentially provide an enriched set of themes the researcher felt it was appropriate to obtain the support of a fellow professional who was familiar with Counselling Psychology and with IPA research to review the emerging themes in Valerie's transcript (see Appendix 6), which was particularly rich. The consequent analysis provided both an element of inter-code reliability, reinforced the validity some of the researcher's interpretations and challenged the validity of others, which were subsequently revised as appropriate. It was suggested that the emerging theme 'duration of therapy' be better described as 'endings' (this later became 'I am very different with clients' dependency now') and also that the sub-theme of 'feeling trapped', which was well supported by the data, was better included within the sub-theme 'feelings experienced by Counselling Psychologists'. The theme of 'trust and respect' appeared to be more speculative

and therefore became absorbed into the sub-theme 'they have to feel safe'. This process also provided a measure of 'researcher triangulation' (Banister et. al., 1996) potentially reducing the occurrence of researcher bias and confirming the dependability of the research (Robson, 1993).

CHAPTER 4

RESULTS AND ANALYSIS

Analysis of data from interviews

The interview schedule set out in Appendix 3 was used as the basis of each interview and whilst semi-structured in nature the researcher tried to ensure that each area in the schedule was covered by using prompt questions where necessary. This was done to try to ensure that equivalent data was potentially available from all 8 participants. Each interview commenced with the same question, asking each participant whether they, as a Counselling Psychologist, considered the therapeutic relationship to be important in their work. Starting the interviews in this general way helped establish a rapport with the participants and obtaining their views on the role of the relationship was a helpful starting point given that dependency, which is the focus of the researcher's investigation, arises in the context of relationships with others. As the nature and quality of those relationships is likely to affect whether clients become dependent on their therapist, the therapeutic relationship acts as an important backdrop to dependency.

Each interview was recorded and transcribed by the researcher and the resulting transcripts formed the raw data for analysis using IPA (Smith, 2004). When listening to the interviews the researcher paid careful attention to the participant's tone of

voice, pace of speech and listened for any inflexions to provide additional data not evident from the face of the transcripts. The transcripts were read several times to aid familiarisation with the data and what seemed to be important passages or phrases were annotated. The researcher also underlined particularly resonant passages and noted their interpretation of the text in the right-hand margin. Next, the left-hand margin was used to note emerging themes which were initially unstructured but provided some cohesion around an identifiable concept. The analysis involved coding themes generated by the participants, which required a detailed, iterative reading of the transcripts and required the researcher to become intimate with the material over an extended period of several days. This level of familiarity ensured that the analysis phase of the research was informed and comprehensive. The researcher then refined the themes and sub-themes, rejecting interpretations which were less well supported by the entirety of the data and refining those that emerged with greater resonance. On completion of this process provisional labels were devised, which were noted on the left-hand hand margin of the transcript. These were then listed on a separate sheet in chronological order, from which the researcher was able to identify any overlap and to look for some order amongst the wide range of concepts and ideas and to extract master themes with supporting sub-themes, which were re-checked to ensure they were represented in the verbatim transcript. The process then continued using the master theme list from the first interview to begin the analysis of the next transcript, searching for more instances of the themes already identified from the first interview but allowing for the identification of new themes as they arose. This process continued until all 8 transcripts had been exhaustively analysed. An

interview transcript from the interview with Valerie, with emerging master themes and sub-themes is attached as Appendix 6. The final stage was to produce a master list of coherently ordered overarching categories and associated master themes annotated to indicate where each theme could be found in the transcript. In addition at this juncture certain idiosyncratic themes were rejected. The resulting consolidated table of participants' master themes is set out in Appendix 5. From the analysis of interview data 4 master themes were identified and 11 sub-themes, which are summarised in the table 1 and presented in more detail below.

Table 1 Master Themes

Master Themes	Sub-themes
The therapeutic relationship as the context of dependency	<i>The therapeutic relationship is 'absolutely fundamental ... that's what it's all about'</i> <i>'they have to feel safe'</i> <i>Boundaries and client dependency</i> <i>'I am very different with clients' dependency now'</i>
Feelings engendered by dependency	<i>Feelings experienced by Counselling Psychologists</i> <i>Feelings experienced by clients</i> <i>Reciprocal feelings of dependency – 'needing to be needed'</i>
Impact of the theoretical approach and the environment on dependency	<i>The theoretical approach</i> <i>The therapeutic environment</i>
Power	<i>Dependency and the balance of power in therapy</i> <i>Empowerment</i>

Participant details are set out below in Table 2, which includes some basic demographic information and length of experience, which participants regarded as relevant to their attitude and reaction to client dependency. Whilst all participants were Counselling Psychologists, details are included of their additional qualifications, which the researcher believes may have influenced their attitude to dependency in their work. What also emerged from the data was the influence of

client presentation on the participants' experience of overly attached clients and in particular the relationship between individuals with an addiction to drugs and alcohol and dependent personality traits and behaviours, which is supported by the literature.

Table 2 - Participant Details

Participant	Age	Gender	Years qualified	Overall years of therapy experience	Other counselling qualifications	Approach used	Clients
Gwen	63	Female	13	22	Psychotherapist	Integrative	All presentations & Eating disorders
Jenny	40	Female	5	8	None	CBT	Drugs & Alcohol
Valerie	62	Female	11	25	Diploma: CBT; Diploma: brief strategic therapy	CBT/person centred	Drugs & Alcohol
Rose	52	Female	12	18	Psychoanalytic training; Post graduate diploma: CBT	CBT	All presentations
Simon	45	Male	9	9	None	Integrative	All presentations
Sarah	49	Female	8	8	Psychotherapist	Psychodynamic	All presentations
James	52	Male	5	5	None	CBT/Schema therapy	Drugs & Alcohol
Mary	64	Female	10	10	None	Integrative	All presentations & Eating disorders

Use of terminology by participants

As detailed in the literature review in Chapter 2, Bornstein (1993) had concluded that there was no universal definition of 'dependency' and this was evident from the varied terms used by participants when referring to the phenomenon in the course of the interviews. They made reference to forming a connection with their clients and providing an environment of support, each of which is represented in

the Oxford English Dictionary (1973) definition of 'dependency'. Participants spoke in terms of being influential to their clients and having clients 'rely' on them and 'push' them (Collins, 1999). They also used terminology consistent with Webster's (1913) definition of dependence; referring to having a 'connection' to their clients and there being a 'reliance' on them. Having control over their clients was also evident when participants spoke about the power dynamics in the therapeutic relationship.

Each master theme is considered below in turn and is illustrated with verbatim extracts from the interviews. In interview extracts: square brackets indicate that certain material has been omitted either at the request of the participant or because it contained details which might identify them.

Master Theme 1: The Therapeutic Relationship as the context for dependency

The therapeutic relationship acts as the context for dependency to arise. It forms the crucible in which dependent behaviours can be exhibited by clients and as such is vital to any understanding of client dependency. The nature and quality of the therapeutic relationship as evidenced by its specific characteristics was seen to play a crucial role in whether clients become dependent on their therapist. Participants emphasised the importance of trust, respect, safety, support, congruence, transparency and empathy in establishing a good working alliance, which was seen as the cornerstone of therapeutic work. An important feature of the therapeutic

relationship was the maintenance of appropriate boundaries, thought to be important in terms of managing client dependency and being seen as a way to mediate against clients becoming overly reliant on their therapist.

Sub-theme 1: The therapeutic relationship is 'absolutely fundamental ... that's what it's all about'

All participants had definite views about the role the therapeutic relationship plays in the therapeutic process and in particular that dependency is unlikely to arise without clients feeling safe and secure with their therapist. All participants agreed that the therapeutic relationship was relevant to therapeutic outcome, with the majority feeling it was the corner stone of effective therapy whilst others put a lesser emphasis on its role in therapeutic change. The strongest views were propounded by Gwen who had 22 years of experience.

'I think it is absolutely fundamental. I think that's what it's all about, the relationship ... establishing a relationship that the client feels safe in cannot be underestimated - it's what it's all about.'

James, who worked in addictions, believed that building a relationship with certain vulnerable clients was fundamental.

'If clients are very damaged; they may not have had a nurturing relationship in their lives at all and their addiction might be driven by schemas around rejection,

abandonment, failure, very strong strains of self criticism, low self-esteem and so forth, so building a relationship with a client like that is fundamental.'

Rose, who was working in the NHS with clients for up to 20 sessions using a CBT approach, was the only participant who held a different view about the role of the therapeutic relationship, which had changed with increasing experience.

'There would have been a time when I would have said the relationship is the key I think to helping clients change ... to make significant change in their lives' and went on to say ***'I have got much less interested in those concepts about the relationship over time.'***

This difference in emphasis on the role of the therapeutic relationship over time seemed to be grounded in her view that that clients ***'want a good enough relationship with you, they want you to be a skilful psychologist with ideas, they don't necessarily want you to be their best friend.'*** In saying this she seems to be making a very clear distinction between the professional nature of the therapeutic relationship and social relationships. The need to be clear about the boundary between professional and social relationships seemed to be something that Jenny is also concerned about.

... 'there might be some patients along the way who perhaps not in this setting but in other settings that potentially, if you are out socially, you would be none the wiser and you could probably get on with quite well.'

When Jenny spoke she sounded concerned that it might be quite easy to like a client and want to have a social relationship with them but she was aware of the risk of there being misunderstanding or misinterpretation. She seemed to be very aware of the ethical issues around forming social relationships with clients.

Apart from Rose the other participants felt that the establishment of a good therapeutic relationship was just the starting point of their work, with Sarah describing the relationship as;

‘the bedrock which allows a transference to develop and holds the patient if particularly negative feelings come up if you have a good bedrock ... then that allows some deeper work to take place, allows the patient to develop and make shifts and feel safe enough to try out new ways of relating’.

For Sarah, who used a psychodynamic approach in her private practice, it seemed that establishing a bedrock was a pre-requisite to any therapeutic work and was particularly important when establishing the type of environment that allows clients to feel contained enough to express difficult feelings such as powerful infantile feelings of dependency. Sarah refers to transference being able to develop if the conditions in the therapeutic relationship are conducive, which she regards as fundamental in her psychodynamic work with clients. Client dependency, from a psychodynamic point of view, can be looked at as a purely transference based response in that it is the re-playing in therapy of historic relationships in which

dependency needs may have been fulfilled or unfulfilled that inform and shape the client's relationship and behaviour with their therapist.

Sub-theme 2: 'they have to feel safe'

Whilst all but one participant felt that the therapeutic relationship was central to the therapeutic process, all participants acknowledged that the relationship was the context in which clients could display dependency needs. It was accepted that in order for clients to feel able to display these needs they would have to experience an atmosphere of safety and security. The creation of such an atmosphere was seen as the consequence of the existence of a number of qualities in the therapist and features of the relationship itself. Whilst participants seemed to find it difficult to prioritise these qualities, they all expressed views on the types of qualities they regarded as important. In so doing the more experienced practitioners gave the impression that they spoke from a position informed by their experience rather than merely quoting 'text book' qualities. The impression given was that the greater the experience of the participant the more they had to draw on when outlining the qualities they believed to be important. Whilst it was their experience that informed their view, this could be no more than a belief on their part; because the inquiry is subjective in nature, it can never be possible to know definitively what qualities are important in the therapeutic relationship. From the therapist's standpoint, what was regarded as important was their ability to convey trustworthiness, respect, empathy and congruence or genuineness towards their clients and also to be transparent in their dealings with clients. Others qualities

related to the provision of a safe, supportive and containing environment. There were certain qualities that stood out as being more important than others with the creation of an atmosphere of trust being emphasised by half of the participants. Gwen regarded this as a reciprocal phenomenon: '**... the most important is trust I suppose; it is establishing an atmosphere where the person feels that they can trust the therapist also that they will be trusted too.**'

Mary stressed the importance of clients feeling safe and knowing that the therapist will protect their vulnerability and also acknowledged that dependency arises where clients '**have trust issues and they have been very hurt ... there is in the beginning a natural type of dependence because they have come for help.**'

For Sarah the important qualities were the person centred (Rogers, 1948) qualities of '**warmth and positive regard ... I just feel those are the fundamentals I suppose and empathy and congruence.**' These person centred core conditions are frequently quoted as the starting point for all therapeutic relationships and it was not clear to the researcher whether Sarah was basing her observations on her experience from her client work or whether this was merely a reference to well known theory.

The importance of warmth was also emphasised by James: '**the most important aspect of the relationship ... are genuineness and warmth ... if you can establish**

something warm between somebody in the first session then you're in a position to do some work with them and that warmth has to be genuine'. For James warmth and the need to be genuine in the therapeutic relationship was a fundamental, and without it he believed it would be difficult for him to do any effective work with his clients. When he spoke he seemed to be basing this very much on his experience of working with clients who had drug or alcohol dependency issues.

Simon reported feeling very anxious early on in his practice about clients displaying dependency needs and believed there were certain qualities that could be displayed by a therapist to try to discourage an over reliance on the therapist. He felt that ***'there is a key challenge for the therapist to be transparent and to be honest about what therapy can and cannot do.'*** This need for transparency and honesty expressed by Simon sounded like a self-protection mechanism deployed by him ensure that clients' expectations were not unduly raised about what therapy can do for them.

When asking about how qualities of the therapeutic relationship impacted client dependency, mutual aspects such as collaboration between therapist and client and mutual respect were felt to mediate against dependency. Being honest and transparent was a declared part of Simon's strategy to avoid clients becoming dependent on him. Valerie also saw the relationship ***'as an alliance ... that meeting***

the client on an equal footing is core' emphasising the centrality of the alliance to therapy.

James, who did not own having experienced client dependency and reported that he was working in an empowering and collaborative way so as to discourage dependent behaviours, thought that collaboration between therapist and client was ***'probably one of the most fundamental aspects of the work'***. He went on to provide some further insight into the reasons behind why he believes collaboration is important for him when he said:

'It's ensuring you are including the client in a relationship. If you are not, there are all sorts of opportunities for a power dynamic to build for the client to feel undermined or their problems are being minimised or invalidated.'

Issues of power inevitably surface in therapeutic relationships (Totton, 2006) and it seems that James is acutely conscious of these issues and tries to use a collaborative approach with his clients to mediate against power differentials. Issues of power arising from the research data will be examined further in Master theme 4 (Power).

Sub-theme 3: Boundaries and Client Dependency

Closely tied up with what Simon described above as the need for 'transparency and honesty' in therapy is the operation of therapeutic boundaries. Totton (2010) writes

about how the developing concept of appropriate boundaries is increasingly forcing therapists into defensive practice and how this approach can prevent the provision of the therapeutic environment needed by the client. Consistent with this thinking, all but one of the participants spoke about the use of appropriate boundaries in the therapeutic relationship as a means to mediate against dependency. This included ensuring that clients know the expected duration of therapy from the outset, which was thought to be helpful in terms of cultivating their independence as they held in mind that their therapist would not be there forever. Participants believed that the use of boundaries was something that helped clients feel safe and secure in the therapeutic relationship and needed to be put in place at the outset.

When Gwen was describing what client dependency meant to her in her practice she spoke about it as ***‘a question of balance ... allowing some sort of dependence, dependence in the sense of being a dependable person’***. For her it ***‘was terribly important in terms of setting sessions and sticking to time and ... sticking to time boundaries’***. She seemed relieved that after a very difficult experience with an ‘extremely needy’ young female client early on in her career, who became highly dependent on her and from whom she found it almost impossible to escape, even though she became ill, she has avoided having anybody ‘harass’ her or ‘over reliance’ on her go too far. The use of the word ‘harass’ indicates a significant level of difficulty with her initial experience of client dependency and seems to convey a sense that this is not something she wishes ever to repeat. She understands that using boundaries will protect her from unwanted dependent clients.

'I think that may be because I have probably ... erred on the side of being clear that I was not available to people outside session times and sticking to time boundaries and that kind of thing. I think we do have a responsibility to establish those boundaries at an early stage.' The use of the word 'responsibility' conveys the idea that establishing boundaries is part of the professional duty of the therapist. This need to be very clear about boundaries is something echoed by Rose who emphasised the fact that clarity is needed about the nature of the relationship between therapist and client, with clients having to understand that it is a professional relationship and not have expectations that it is more. For her this was fundamental to clients being able to access their own resources and 'stand on their own two feet'.

Sarah also emphasised the importance of the role of appropriate boundaries in the therapeutic relationship but instead put the emphasis on promoting an atmosphere of safety and security for her clients:

'I do think it's quite containing for the client to have quite clear boundaries and I think they can become quite worried if those aren't maintained'

Whilst she saw boundaries as important she also felt that sometimes flexibility was needed, recognising that occasionally something gets enacted which might lead to a relaxing of the boundaries, resulting in some contact taking place outside the session. She had experience of clients contacting her by email or telephone and this was something she was tolerant of if she regarded as appropriate in the

circumstances. Gwen, who had 22 years of experience, was also more relaxed now about the need to maintain rigid boundaries than at the beginning of her career. She also gave clients her mobile number and was happy to receive and send texts within certain specified parameters. Mary was also prepared to give clients her mobile number but she was very clear about when she would be able to listen to messages and return calls, which she regarded as maintaining a sufficient boundary in relation to out of session telephone contact. Jenny had similar sentiments about boundaries in therapy, seeing them as important but also believing that holding them too rigidly could be unhelpful at times.

James likened boundaries to structure, which he regards as helpful to both therapist and client describing them as ‘inoculating’ the therapy against dependency. His use of the term inoculation suggests he sees dependency as an illness or a disease against which you can be protected. This idea is evident in other parts of his narrative where it is clear he works hard to ensure that clients do not come to rely on him in an unhealthy way. When speaking about the benefits of structure he sounded critical of practitioners who are not well prepared and simply asked the client ‘so how have you been this week?’ This seems to be tied up with his sense of professional pride in the discipline of counselling psychology which he believes ‘***demands rigour as well as sensitivity and warmth and genuineness***’, seeing Counselling Psychologists as ‘***highly skilled therapeutic practitioners, scientists***’. He focuses on the need for a treatment plan as a way of ensuring that the client understands that therapy is not ‘going to last forever’. He demonstrates

his use of boundaries in response to a client who starts to show dependent behaviours saying: ***'it would be essential to start reinforcing [boundaries] if it became apparent from what they were saying or how they were behaving that something was building in terms of dependence.'***

Simon, who is clear that he tries to prevent clients becoming dependent on him by being very clear about what therapy can offer, also spoke about how he used boundaries in his practice to try and manage a dependency which had arisen with a client who he describes as ***'going through, in the psychodynamic sense, necessary dependence'***. He is aware that notwithstanding his efforts he ***'can't control whether she emerges from that'*** but he is doing his best with a particular female client ***'to help her to work things out for herself; it would be very easy with someone like this to run over time and perhaps to get involved in some kind of communication outside of [therapy] and none of that is happening so it's very contained'***. He seems to have identified the possibility that it would be easy to relax his boundaries with this client and is guarding against that. Whilst Totton (2010) has highlighted the operation of boundaries as potentially preventing the provision of the therapeutic environment needed by the client, the overriding impression given by participants was that boundaries were a positive tool for use in the therapeutic environment. Even though less experienced participants seemed more inclined to hold firm boundaries the more experienced participants were willing to relax boundaries, where they believed this would be appropriate.

Sub-theme 4: 'I am very different with clients' dependency now'

Half the participants interviewed believed their length of experience had an impact on how they worked with dependent clients. Initially they had found overtly dependent behaviours very difficult to deal with and had not known how to talk about these issues or, in some cases, how to work with them. Simon talks about dependency behaviours as something that he initially 'struggled' with saying that:

'I can see how my own lack of experience and naivety, lack of self awareness on a deeper level led to a kind of mutual dependency on occasions'. He pauses for a few seconds before referring to the implications of this lack of experience, suggesting he is a little ashamed that he found this difficult, which conveys a sense of inadequacy and even self-doubt about his abilities as a therapist at the beginning of his career. This has changed over time for him:

'I get much less stressed now than I use to because of that slow, gradual process of becoming aware through experience over time of how these process and issues play out.'

The sense is that inexperience led not only to clients becoming dependent on him but also some feelings of mutual dependency, which was anxiety provoking at the start of his counselling psychology practice. Although he feels he ***'struggles less'*** with this now he makes reference to ***'constant vigilance'*** suggesting he guards against dependency behaviours. He feels that it is ***'most important being transparent with people and being straightforward, helping people to explore their own dependency needs and being realistic about what therapy can and can't***

do'. His use of the words 'struggle' and 'constant vigilance' suggests battling with something or fending off something that might attack. This anxiety and even fear about clients becoming overly reliant is something that is echoed by other participants and is explored further in Master Theme 2: 'Feelings engendered by dependency'.

In contrast to Simon, James felt that his approach had not changed with experience. It is interesting to note that of all the participants interviewed James had the shortest experience, only working for 5 years as a Counselling Psychologist, although he had been a drugs and alcohol worker for many years prior to qualifying. Length of experience seemed to be strongly influential in how dependency was thought about and how it was worked with by participants. Whilst participants had worked as Counselling Psychologists for between 5 and 13 years, many of them had much greater experience of working in counselling or helping roles, with Valerie having over 25 years experience, Gwen 22 years experience and Rose 18 years experience (see table 2 above for details of all participants experience). Participants with greater experience seemed to be much happier dealing with dependent clients and could acknowledge how their attitude had changed during the course of their careers. It was these more experienced practitioners who described in detail their experiences of clients becoming over reliant on them and in the case of Gwen and Valerie, the two most experienced Counselling Psychologists, how they had felt 'stuck' or 'glued' to these clients in such a way that made 'escape' difficult. This is explored in Master Theme 2: 'Feelings engendered by dependency'.

Gwen acknowledged that she was very different with clients' dependency needs now from how she was when she started out, saying when she thought about ***'an unhealthy dependence, an over-dependency.... what I have learnt over the years is that if I felt it happening I would definitely bring it up and work with it.'***

Jenny also found it difficult ***'in the beginning ... actually putting these things on the table with patients because it almost feels like a social taboo.'*** The use of the expression 'taboo' seems to indicate something that is unspeakable or difficult to discuss. This idea that dependency is something uncomfortable and difficult to mention to clients was supported by a number of the participants and suggests avoidance rather than acknowledgement may have been operating.

There seems to be a common theme in that the greater your experience as a therapist the more comfortable you become with difficult feelings and situations in general. This is likely to be a fairly universally held view and not something that relates solely to dealing with client dependency. There are a whole range of things that can arise between therapist and client that are likely to become less anxiety provoking for therapists with greater experience.

The interview data strongly suggests that the nature and characteristics of the therapeutic relationship, which acts as the context for dependency, plays a crucial role in whether clients do in fact become overly attached to their therapist. This

seems to ignore the psychodynamic view that dependency is a transference response on the part of the client that arises in response to the therapist.

Participants thought that for a relationship to develop conducive to the display of dependency needs certain characteristics needed to be present such as mutual trust and respect; congruence and transparency; empathy and also safety, support and containment for the client. Without these it would not be possible to establish the requisite quality of working alliance seen by participants as the cornerstone of effective therapy. The use of appropriate boundaries, which are regarded as containing and helpful to the client, were also deployed by some participants as a self-protection mechanism to avoid clients becoming overly reliant on them. What also seemed apparent was the greater the experience of the therapist the more relaxed they seem to be about relaxing boundaries if they felt this would be helpful.

Master Theme 2: Feelings engendered by dependency

A whole range of feelings were experienced in relation to dependency from both the perspective of the therapist and the client. The examination of feelings from the therapists' point of view included the feelings experienced by participants when they encountered dependent behaviours in their clients whether they accepted and worked with those behaviours or not. Also included is the fear and anxiety experienced when participants tried to resist the dependency needs they encountered. Clients' feelings engendered by dependency are examined through the eyes of the Counselling Psychologists, who have observed client behaviour, and directly from a client perspective in Rose's account of her experience of becoming

dependent whilst in long term psychoanalysis and her feelings of anger and disillusionment. Reciprocal feelings of dependency arising where participants have felt strong bonds with their clients, which has sometimes felt stifling or was resisted, are considered in sub-theme 3.

Sub-theme1: Feelings Experienced by Counselling Psychologists

Gaining an understanding of the feelings experienced by the Counselling Psychologist participants when clients become dependent is central to the research question. Of the 8 participants, 3 had never had any experience of a client becoming dependent on them in their practice, or at least they had not been aware that dependent behaviours might have been exhibited by clients. When behaviours that have been associated with dependency in the literature were explored with participants, such as contacting the therapist out of hours, being reluctant to end therapy and asking for more sessions, all participants agreed they had some experience of this but had not perceived it as being associated with dependency, instead seeing them as issues relating to the maintenance of appropriate boundaries. The findings set out in Master Theme 1: sub-theme 3: 'boundaries and client dependency' suggests there is a clear relationship between boundaries and dependency in that participants see their use as a means to mediate against dependency consistent with the findings of Tait (1997).

What is apparent from an examination of the interview data is that the feelings expressed by participants in relation to dependency can be extremely challenging and difficult. It seemed that even where participants took active steps to prevent clients becoming dependent on them so as to avoid experiencing these challenging feelings they still had anxieties about their ability to withstand a client's dependency needs. This was evident from the way Jenny spoke about dependency from the position of an observer of the phenomenon in others. She is clearly mindful of clients becoming overly attached to her because declares she is thankful to have avoided being in **'really nasty situations'** so far in her career. This view seems to be informed by her past experience of in a forensic unit where **'there were some nasty things that did happen where certain staff members were targeted ... attachments were formed that had very sinister edges to them [laughs]'**.

The words she uses are very powerful and give a real sense that she is truly afraid of what might happen if she was 'targeted' by a client who wanted to become 'attached' to her. Her reference to 'sinister edges' conveys a sense of something dark and even terrifying. It is noteworthy that she uses the term 'attachment' when she is describing her concerns rather than dependency. The literature traces the historic relationship between attachment and dependency and this will be picked up in the discussion in Chapter 5. Jenny continues homing in on her fear of the unknown saying:

'I think it is ... too frightening where there is that potential in what will happen in the..., how will that person react? What is your reaction etc? Will this escalate and

if it escalates what will that mean for the person? What will it mean for the teams' operational policies, you know, code of ethics all of that stuff?'

This is said with a real sense of panic about something unknown and uncontrollable happening and a concern about the implications of this for her and her team. This is evidenced by her halting speech. Also her use of questions shows she does not have any answers. Her reference to the code of ethics suggests she may be afraid that if clients become overly attached to her there may be ethical implications which might impact her practice. The way she speaks conveys the unpredictable nature of client dependency; she does not know how a client will react or how she will react if they exhibit dependent behaviours which seemed to be highly anxiety provoking for her. Her concern about how issues of dependency might impact her practice is evident when she goes on to talk about her experience of a client who has become dependent on her saying it ***'has felt very difficult because you are constantly thinking that you don't want to do anything or say anything that could be misinterpreted or for you to misinterpret.'*** The repetition of 'you' indicates feelings of personal responsibility in allowing a dependency to arise, suggesting it is something conscious on the part of the client and therefore is something the therapist can influence or even prevent. Her use of the word 'constantly' suggests that this is something that is always on her mind when she is working with a client and the nature of her fear seems to relate to misunderstandings or misinterpretations arising between her and her clients, which links to what she has said earlier about ethical concerns. It is as if her worry is that it might be quite easy to respond to a client's dependency needs in an inappropriate way that might even

jeopardise her practice and her livelihood. This seems to demonstrate that this is a very complex area, which is little discussed in training circles but seems to cause significant concern, distress and even fear for therapists in their client work.

Gwen describes herself as **'standing back'** from her clients and being a **'bit more detached'** in the way she practices today. There is a sense that she does this to protect herself and this seems to be in response to an experience of working with a **'very needy young woman'** when she was very inexperienced, who became very dependent on her and who she continued to see throughout her own serious illness. The researcher got a strong sense that she felt that it was her fault that this dependency arose because she describes making a **'basic mistake...right from the word go'** in deciding to sit close to her client on a small sofa. When she noticed that she was 'too close' she moved away but moved back when the client asked why she had moved. This physical closeness was very uncomfortable for her and somehow her decision to move away and move back when challenged by the client seemed to set up some kind of obligation to the client. She describes her experience as:

'It was like we were stuck we were glued together on this sofa and she was one of those clients who would fix her gaze on me and I felt that I couldn't, I could hardly look away.'

The use of the words 'stuck' and 'glued' mirrors the baby, who is dependent on the mother, and is glued to the mother's breast. Her inability to look away conveys a sense of feeling trapped and unable to escape. Her description of being fixed with

her client's gaze sounds as though she may have been afraid even to look away, let alone escape in any physical sense. She does not escape but instead she continues to work throughout her own illness at serious personal cost. This is a measure of how responsible she felt for this needy young woman in that she put the client's needs ahead of her own. She is now able to acknowledge that she paid a high price in not letting go of this client.

'Looking back on it I think the whole thing was thoroughly unhealthy and I don't think it did her any favours and it certainly didn't do me any favours. I really should have looked after myself better'.

The acknowledgement that this was 'thoroughly unhealthy' and that she should have looked after herself better recognises the self sacrifice that was involved in allowing this dependent relationship to continue. With the benefit of hindsight she can see that she should have acted differently but there is a sense that at the time she was powerless to escape.

Feeling trapped is echoed in the narrative of Valerie who describes as a ***'trap'***, her decision to go into areas other than addictions with a client who she describes as ***'a bottomless pit of need'***. She chastises herself because she should have known better in that she was never going to be able to satisfy her client's needs and therefore she should not have opened things up. She gives the impression that she feels responsible for creating this trap for herself when she says:

'Every time I try to find somewhere to hand her on to I let her come back because I've created this dependency [pause] and in the end I'm going to let her down.'

For Valerie the trap seems to be that creating this dependency brings with it responsibility and the necessary acceptance that she will inevitably let her client down. This seems to be accompanied by a sense of guilt. Worrying about being unable to fulfil a client's expectations was also evident in Mary's narrative when she said:

'if a patient becomes very dependent on me then I start to feel; well, what are all these expectations about? And I know that I can't deliver them. I suppose none of us can deliver them all and I don't want to be in that position of them finding out [laughs] that I can't'.

She does not want her client to find she is not able to fulfil their dependency needs. The reference to 'them finding out' suggested that was something she wished to keep secret and did not want her clients to discover. Her laughter also indicated that she was uncomfortable with acknowledging that she cannot meet all her client's demands, possibly suggesting a sense of inadequacy.

Sarah regarded working with clients' dependency needs as a particularly important part of the psychodynamic therapeutic process but even so she had some strong feelings about how it impacted her practice, giving the impression that she regarded it as a necessary evil of her work. She described powerful feelings on her part emerging in response to a particular client's dependency and how she

responds to those needs by what she described as 'giving in' to the demand for extra sessions. ***'I can't give her enough and I feel very powerfully I'm not good enough with her and therefore I feel that I have to sometimes offer her an extra session to mange ... and then there is a sort of relief.'***

This sense of relief is accompanied by difficult feelings of being tested, struggling and failing:

'She tests me all of the time and I think that she sets me up to fail in a way by testing me so much and it's really hard and I do struggle with her a lot and yes and the trouble is then when you do say give an extra session or try your best and it's still seems to be failing somehow'.

This conveys the sense of being in a real catch 22. Her feelings of failure are accompanied by anger and questioning why she continues to work with this client when the personal cost seems to be so great. She acknowledges that she feels 'attached' to this client and that despite 'mixed feelings' she feels she should persevere, which conveys something to be endured and to be overcome. Sarah seems to be focusing on the balance between boundaries and boundlessness and acknowledges that she is willing to relax her boundaries by offering her client an extra session if pressed and even if this is a difficult decision it is accompanied by relief when she acquiesces.

'Often I just feel so angry with her I think I don't know why on earth am I seeing her I feel this attachment to her, I want to persevere with her... but it's very

mixed feelings at times especially when I feel rubbish, when she has really rubbished me [laughs].

Feeling like rubbish because she has been rubbished sounds a very diminishing experience. Her language conveys the idea that the experience makes her feel worthless and, like rubbish; that she can be thrown away. In listening to Sarah there is real sense that she is trying to balance spontaneity in her practice with control and that this is a struggle. She recognises this is a balancing act and one which is personally costly, which is evidenced when she says:

'rage is not far under the surface with her and I never feel quite sure when it's going to erupt and when it does its awful I have a physical reaction to it my heart starts beating quite fast and ... it does make me feel quite impotent when I am with her so it's not always so helpful [laughs].'

Her acknowledgement that 'it's not always so helpful' shows she is aware of the personal toll working with this dependent and demanding client has on her. Her laughter suggests a realisation that withstanding this client's level of dependency need, where she actually has a physical reaction to its power, maybe a high price to pay for the therapeutic benefit of working with dependency issues in general, which she sees as often central in psychodynamic work. Later in the interview Sarah reflects on her experiences with two different clients describing one where she feels ***'that the dependency is contained, more contained, can be thought about, can be addressed'*** and another as where ***'I do struggle much more ... to manage the dependency that comes up with her'*** where she feels ***'much more inadequate.'***

The inference is that the therapist's experience varies with different clients

depending on their respective history and also the history of the therapist, supporting the idea that therapy is a co-construction. This, or transference and counter transference, is not specifically referred to by any of the participants, not even by Sarah, who uses a psychoanalytic approach in her practice.

Mary, who was adamant that she did not want clients to become dependent on her, feeling it would be a **'burden'** for her, was afraid that clients would discover that she could not meet their expectations. She had witnessed dependency on a colleague, which had resulted in their physical detention by a patient and this had left its mark on her. She believed that dependency was an unconscious behaviour and therefore can arise without any encouragement from the therapist. Like Gwen and Valerie, Mary also identified a fear of **'feeling trapped'** and described being glad to **'escape'** and being on her guard when she witnessed dependent behaviour.

The feelings experienced by participants where clients become dependent on their therapists were very powerful and seem to have a significant impact on the participants' therapeutic work. Even where the theoretical approach used recognises the importance of working with infantile feelings of dependency, this does not counteract the strength of the therapist's reactions. It is recognised that there is a price to pay if a client's dependency needs are to be explored in the course of therapy. There is a sense of it being very painful to experience dependency needs and real difficulty in breaking away and being set free from such

feelings. Even if dependency is not actively worked with in the here and now, the fear that it might arise is highly anxiety provoking for participants. In terms of the strength of the feelings experienced Sarah, who actively worked with dependency needs, used the most vivid language when describing her reactions to dependent clients. However, the use of such language was not representative of the other participants. Jenny also used strong language to convey her fear of dependent behaviour arising at all. It is possible that her fear resulted in her adopting avoidance tactics which may heighten her fear.

Sub-theme 2: Feelings experienced by clients

As well as most participants experiencing strong and difficult feelings about client dependency themselves, two participants described the feelings they witnessed in their clients. To a large extent there was a crossover with the feelings experienced by the participants. If this were to be viewed from a psychodynamic standpoint it could be understood in terms of transference and counter-transference and whilst this terminology was not directly used by any of the participants, Sarah seems to be referring to transference when she talks about dependency in the therapeutic relationship enabling powerful infantile feelings to emerge in the client. In addition to participants' observations of their clients' emotional reactions to dependency, Rose shared her own feelings from a client perspective of becoming dependent on her therapist during long term psychoanalysis. This account was extremely powerful and moving and provided some direct insight into dependency from the client's perspective.

When talking about the impact of client dependency Jenny identified how the therapist's fear, which is discussed in sub-theme 1, could be projected into the client saying that:

'When you start to feel frightened then how can you make the patient actually feel safe? ...they get frightened.' Jenny is touching upon how fear of dependency needs can be extremely pervasive; spreading from the therapist to the client and even to the organisation which offers the therapeutic service. Whilst Jenny's principal response to dependency seemed to be fear, Sarah felt dependency was useful in order to facilitate a particular way of working with her clients although an awareness of their vulnerability was also important.

'I think that dependency in a therapeutic relationship can allow powerful infantile feelings to emerge which can then be thought about together ... the other side of dependency is the feelings which it evokes in the patient or the client because it can make one feel incredibly vulnerable.'

Sarah went on to identify the importance of therapist awareness of the regressive feelings that can emerge and how in that context they need to assess whether the client has the ego strength to manage the dependency that arises during a session and then to emerge out of it and manage until their next session. There was a sense that this requires careful assessment on the part of the therapist and an acknowledgement that not all clients will have the requisite ego strength to work in

this way. When she continued to talk about her work with a client that she found challenging she acknowledged that:

'...we are working quite well together as long as we can survive her anger and her feelings of disappointment in me and rage that I'm not offering her what she wants.'

She seems to be suggesting that the client's dependent feelings can only be worked with if she can survive their anger at not providing what she wants. This is a high price for a therapist to pay. The implication is that the client is only able to experience these 'powerful infantile feelings' of anger rage and disappointment in her therapist because she has become dependent on her, which suggests there are important positive aspects to expressions of dependency from a therapeutic process standpoint. What she appears to be describing is the transference phenomenon, which can be seen as the client's unconscious attempt to generate the appropriate empathic response from the therapist. She describes her work with this particular '***patient***', which she observes is '***interesting in terms of dependency***', suggesting something about power dynamics, in the following terms:

'I am seeing her 3 times a week and she's using the couch, so I think a dependent relationship has arisen. It's about her allowing a certain level of trust in me to develop and intimacy and then when she struggles with that then it's around areas I suppose of dependency. She worries about being dependent on me.... it does take quite a lot of work on the part of the therapist to contain those quite powerful feelings.'

If therapy is regarded as a place to re-experience early formative relationships, then having dependency needs met by the therapist can provide a route to independence (Winnicott, 1965). In the sample of 8 Counselling Psychologists interviewed only 3 recognised the therapeutic benefits of working with dependency needs, the principal proponent being Sarah with her psychodynamic influence. Gwen, who was an integrative therapist, was sensitive to dependency needs but did not actively work with them and Simon, whilst acknowledging the theoretical stance, actively resisted dependency needs.

The clients' perspective was provided by Rose in a passionate account of her experience of being in long term psychoanalysis and her feelings of anger and disillusionment with her experience of dependency on her analyst. She commenced this difficult subject by saying that she had recently been reflecting on her experience of being in therapy for more than 4 years and has realised what a waste of time and money it had been. The word 'waste' suggests it had been of little or no value and had also taken up valuable time. This was something she felt very strongly about, saying that she was against very long term treatment with a psychoanalyst because her hopes that she could sort out her problems and undergo some fundamental change were dashed when at the end of treatment her problems resurfaced and she did 'not have any resources to fall back on'. There was a sense of her investing a lot and having high expectations of therapy and feeling disappointed when it did not help her add to her resources. Resentment is evident when she acknowledges that her dependency was fostered and there is a strong

sense that she felt marooned and left with nothing 'to fall back on' - independence had not been achieved out of dependence (Winnicott, 1965). She spoke about her therapist being the one who 'unscrambled' her head rather than helping her to find ways to do that. She did not feel her therapist had actively fostered her dependency but instead they had failed to properly set out the expectations of therapy. She goes on to say:

'I have felt very angry about especially when it stopped and when I got into difficulties again especially in recent times I thought ... I'd like to give him a piece of my mind [laughs]'

When Rose is talking about her personal experience of dependency she is very emotional. She is unable to describe what she is angry about; she is speechless. It's as if she gave control to her therapist and then when therapy ended she was cast adrift, without a lifeline. In the way she speaks about this experience strong feelings of anger and resentment at her treatment can be detected. It sounds as though she believes her dependency arose from a lack of structure in the therapeutic process, something which she is very keen to promote in her own practice with clients. No expectations or objectives were set so that when the 'active treatment' came to an end when she had sorted out her problems, there was no acknowledgement that it was a good time to finish or even an assessment of whether it was time to finish. She talks about continuing to go 'along for a chat', using language which seems to diminish the value of the therapy and her laughter suggests she is veiling anger, which is more explicitly conveyed by her saying she would like to give the therapist

a piece of her mind, which is a colloquial way of saying she would like to tell off the therapist for the impact the therapy has had on her.

Sub-theme 3: Reciprocal feelings of dependency – ‘needing to be needed’

A link was identified by some participants between clients becoming overly reliant on their therapist and reciprocal feelings of dependency of the therapist towards their clients. This was recognised as taking different forms, from practical things such as depending on clients to make a living to the psychological needs of therapists. Participants also identified their need for some kind of personal reward for the work they do; feeling that they need to be personally valued. Jenny acknowledged this by asking rhetorical questions about need:

‘... for the therapist how much of us has a need to be needed, how much of us has a need for a different kind of attachment than we have in our own everyday lives?’

Gwen echoed this idea of importance to the client when she talked about therapy as being the only place where the client can crumble and recognised that she was the ‘only one’ who witnessed this. She felt that clients can often not manage or survive without the therapist since it is the therapist who provides a life line for a floundering client. Gwen recognised that clients may want the therapist to be everything to them and this emotional dependence can make the therapist feel ‘valued’ and ‘worthwhile’. Gwen had also witnessed other therapists who acknowledged having an ‘investment’ in their clients, becoming dependent on

them, but she felt that this was not something anybody really wanted 'to talk about'. There was a sense that having clients become dependent made them remain in therapy longer, which appealed to some professionals. For herself she acknowledged her emotional and psychological needs in that her work needed to make her 'feel good'. She was the second most experienced of the participants interviewed and had a pragmatic stance saying she would aim ***'to be important to [her clients] but not to be the only thing that's important to them or the only relationship that's important to them.'*** She was realistic about her role, feeling it was crucial that her clients had faith that they could survive without her. In recognising this she was diminishing her importance in the client's life, which she later re-emphasised by observing that therapist should not 'over-value' their importance.

Recognition of the therapist's own need to be needed by their clients was also identified by Sarah when she asked:

'... why are we doing this work unless we somehow we get quite a lot from it. So perhaps we do need our patients more; we learn a lot from ... our clients ... it's a little bit disingenuous probably to say that I don't depend at all on her we have a therapeutic relationship, I have an investment in it.'

Sarah's reference to having an 'investment' in the therapeutic relationship indicates that she feels she has contributed something to it and that this has taken time and

effort on her part with the implication being she should reap some reward from this 'investment'.

The therapist's need to be needed was referred to as 'narcissistic' need by 2 of the participants. This was articulated by Mary when she said:

'I certainly wanted to be thought of as a good therapist, in fact I'd like to be better than anyone else, there's still that secret little line there but that's it, it's just [laughs] just the narcissistic side. '

The temptation to fulfil the therapist's own needs by holding onto clients for longer than necessary was identified by James:

'We need to make a living so ... there is a very direct relationship between the therapist and the client, which you have to reflect on and be very cautious about. It could be relatively straightforward in some environments to keep favoured clients for long periods.'

This reference to the need to make a living highlighted the therapist's dependence on their clients in practical rather than emotional terms. This was also something identified by Simon who was very concerned about the financial aspects of therapy and the possibility of abuse. The temptation to keep working with certain clients for emotional reasons was also evident when Valerie spoke about her experience of not being able to let go of a client, who she described as having been 'passed round

like a tennis ball'. She whispers that she has been working with her for nearly 3 years and refers to her as a 'cover story' for work she was doing as part of some training. The researcher got a real sense evidenced by her whisper that this relationship was like a guilty secret which she protected by not bringing the continuing relationship to the attention of her superiors in the NHS. She seemed embarrassed when she spoke about how long she has been working with the client but this was coupled with a real sense of pride about what had been achieved in working with this client and the role she had played in this.

'I've worked with her in a very creative way and she's got some sort of life in that she can manage things now that she couldn't manage before ...'

Valerie's sense of achievement is further evident when she relays how her client tells others that she is the 'only one' who has helped her. The complexity of this area of therapist's needs was further evidenced by Valerie's sense of confusion when she laughingly described her reaction to a compliment from a client as sending her 'screaming to supervision', which suggested the need to run for help and support.

Sarah was willing to own her feelings towards a male client saying she felt close to him but she seemed reluctant to describe her feelings as any form of dependency on her part saying:

'I am attached to him so [laughs] I don't know whether we would call it ... I would hesitate to call it dependency but certainly I feel very strongly towards him'.

Her laughter suggests that she feels self conscious talking about her 'attachment' to this client and her reluctance to describe her feelings as dependency suggests that she is unwilling to own having dependent feelings as if this would somehow be inappropriate or too difficult to acknowledge. This unwillingness to recognise dependent feelings towards clients was consistently the case amongst the participants who spoke about needing their clients as if there was something shameful in making such an open admission. It was also equally difficult for some participants to acknowledge when they seemed to be unimportant to their clients, particularly if they were doing very little in terms of therapeutic intervention. Simon admitted that ***'there have been sessions where I have said half a dozen words. It has been such a challenge to my therapeutic ego I can't tell you.'***

Reciprocal feelings of dependency was not something mentioned by either of the 2 male participants, who were both very clear that they took active steps to discourage client dependency by being straightforward about the expectations and limitations of therapy from the outset and by maintaining firm boundaries during the course of their work. This was examined in Master Theme 1: The therapeutic relationship as the context of dependency; sub-theme 3: Boundaries and client dependency.

It is clear that participants' experiences of dependency, both in terms of clients becoming dependent on their therapist and therapists feeling dependent on their clients engender strong and sometimes difficult feelings in both the therapist and

client. Whilst not all participants had direct experience of needy and sometimes suffocating clients they all had views about the impact of dependent behaviours, whether these were imagined or real.

Master Theme 3: Impact of the theoretical approach and the environment on dependency

More than half of the participants made observations about the influence of the therapeutic approach on clients becoming overly reliant or attached to their therapist. Some participants regarded psychodynamic approaches as encouraging dependency but short term approaches such as CBT, with its collaborative stance, acting as a positive deterrent. Linked to the theoretical approach was the impact of the frequency of sessions, with sessions that were more frequent than weekly being seen as increasing the client's reliance on therapy. Participants also believed that the overall duration of therapy was relevant to whether a dependency arose, with a belief that longer term approaches encouraged dependent feelings in clients with shorter term approaches generally protecting clients from becoming dependent.

Sub-theme 1: The theoretical approach

Whilst all participants were Counselling Psychologists they practiced using a variety of theoretical approaches (see table 2 above) and also invariably referred to themselves as therapists rather than Counselling Psychologists. In fact 6

participants made no reference at all to counselling psychology even though the researcher's first interview question specifically referred to the discipline, which suggests they are not particularly wedded to this identity. Sarah, who worked using both long and short term approaches, described her main way of working in her private practice as psychodynamic. She believed that the theoretical approach taken, with a particular focus on frequency and duration of therapy was relevant to the phenomenon of dependency.

'I do think sometimes some approaches may promote or allow a dependent relationship to develop more powerfully so particularly I'm thinking about using the couch and using a psychoanalytic framework so seeing people more maybe than twice a week or more than once a week then that is probably going to allow dependent feelings to emerge in the relationship a bit more powerfully and be worked upon than say in a short term focal approach.'

Sarah went on to say that when working in a psychodynamic model therapists needed to be particularly mindful of the suitability of clients for that type of approach given the likelihood of powerful dependent feelings arising.

'I think it's especially important in psychoanalytic psychotherapy for the psychotherapists not to think that everybody is suitable for an intensive three times week therapy because I think not everybody can manage that so I do think it's important for us as therapists to assess, to be aware of dependency and how powerful it is and how it's likely, very likely, to arise in the therapeutic relationship and manage it'

Sarah believes that it as an important part of treatment for clients to be able to demonstrate powerful infantile feelings of dependency and that it is only through this process that they can begin to manage these feelings and emerge from dependence to independence. In contrast to Simon, who regarded increased frequency of sessions as encouraging dependency, Sarah sees the number of times she meets with a client (up to 3 times week when working psychoanalytically) as providing a helpful way of managing dependency and not as a factor that contributes to it arising in the first place. She 'struggles' more with clients who become dependent on her when she is only seeing them once a week, because ***'strong feelings emerge and then they have to wait a whole week before they see me again'***. She is also concerned that therapists make a judgement as to whether the client has ***'the ego strength say to manage the dependency or regression and then emerge out of it and manage for the rest of the week.'*** She says that in psychoanalytic work client dependency has to be ***'handled with extreme caution and some awareness of the powerful effect of dependency feelings arising'*** and goes on to say that this ***'needs to be ... brought to supervision; thought about and reflected on by the practitioner.'***

In contrast to Sarah's view that long term psychoanalytic therapy can help clients work through their dependent feelings, Simon was particularly concerned about the impact of long term work on clients and how a dependency on therapy or the therapist can be hard to leave without help. In addition to the implicit psychological implications of long term therapy he was also concerned about the financial

implications of having to pay for long term therapy, relaying how he had worked with a client to help them leave 7 years of psychoanalysis which they were working at three jobs to pay for. He was concerned about the potential for abuse in the psychodynamic models, which he recognised as having ***'a tendency towards longer terms of engagement ... with increased frequency of meetings.'*** At the heart of his unease appeared to be the ***'significant amounts of money'*** charged by psychoanalysts.

'It really worries me, it really bothers me and that is not to say that I don't understand that for some people that type of therapy can be very helpful but there is a huge emphasis on the practitioner to make sure.'

His emphasis on the practitioner having to make sure that long term work continues to be beneficial for the client echoes what Sarah said about practitioners needing to be aware that not all clients are suitable for intensive psychoanalytic therapy.

Gwen, who works using an integrative approach, made an honest observation relating to her own desire to remain independent when she spoke about knowing a lot of therapists who continued to work with clients for many years. She felt that it could be very beneficial for some clients to be in a long term relationship but she was clear that she has ***'never wanted to offer that because I value my independence.'*** This conveyed the sense that the therapist has to sacrifice something of herself for a dependent client. This is on all fours with the views of

Sarah who recognises the price she has to pay for actively working with client dependency.

Rose was very clear that she does not foster dependency, instead she tries ***‘to be useful to them for a purpose, which is their purpose, which is goal directed’***. She believes that the key to avoiding dependency is getting the client to be ***‘their own therapist’***. In her client work Rose focuses on what she sees as the central aspects of the CBT approach which involves ‘teaching’ and giving her clients ‘tools’ to use. She acknowledged that there are other ways of working but she believes it is much more ***‘helpful to people to know what to do particularly if they have had recurrent depression, panic attacks or very debilitating OCD’***. She seemed to be focusing on what she regards as serious psychological conditions suffered by the clients she sees in the NHS rather than her private clients, who she described as sometimes just wanting to ***‘come along for a chat’***. Rose feels that working in this way helps the client ***‘overcome those problems and to have a better way of understanding their problem and especially the things they can do to help themselves after the treatment has ended.’*** She seemed to firmly believe that this is what helps people to stay well after therapy has ended. She also drew a link between not fostering dependency in her clients and the number of sessions available to them, which is limited to 20 in her NHS practice. Rose did not work with many self funded individuals who could continue in therapy long term but even if they could she would still endeavour to keep the treatment short term, offering follow-up sessions as a way of reviewing progress. In her experience she has never found it to be the

case that her clients ***'can't manage without ... therapy'***. She then laughingly said that if it were the case she would refer them for psychodynamic therapy. Her laughter can be understood in terms of her own experience in long term psychodynamic therapy (see Master Theme 2: Feelings engendered by dependency; sub-theme 2: Feelings experienced by clients) where she described strong negative feelings about becoming dependent on her psychoanalyst; feeling that this dependency meant that she had no resources to fall back when her own problems later resurfaced. It seems clear from her demonstrably negative view of client dependency that her own experience has coloured her approach with her own clients.

Jenny, who worked in a drugs and alcohol team using principally CBT, explained that in the NHS evidence based practice is used to encourage practitioners to work with drug and alcohol dependent clients over the longer term because this has been shown to have a better treatment outcome. It was her belief that seeing clients for longer had implications for client dependency and particularly so because she was working with a client group who, the literature shows, are more likely to become dependent on their therapist because of certain personality characteristics. There was a sense that she did not necessarily agree with the NHS stance when she said:

'... there's a lot that's being pushed towards us about retention and treatment has better outcomes in the longer term so you need to engage people for a certain number of weeks'

Her use of the word 'push' suggests she may have felt her hand was being forced and that it might not necessarily have been her choice to work longer term with certain clients which in her view encouraged dependent behaviours.

From these differing accounts it can be seen that the majority of participants hold strong views that the therapeutic approach itself and the duration of therapy have a significant impact on whether clients become dependent either on the therapist or on the therapy. As to the benefits, as perceived by the participants, of clients experiencing dependency in therapy, views were polarised. This is illustrated by the views of Sarah, who uses a psychodynamic approach, and Rose, who uses a CBT approach.

Sub-theme 2: The therapeutic environment

Half of the participants felt that the context in which therapy was delivered had an impact on client dependency. This extended to the institution where they worked, which included the NHS and a privately funded hospital but not any voluntary organisations. Half of the participants also had a private practice, working from their own home, which they believed had an influence on client dependency, as it seemed to encourage clients to have a sense of being closer to their therapist than would otherwise be the case.

When exploring with James, who did not acknowledge clients having becoming dependent on him, whether his clients had ever asked for extra sessions or contacted him out of hours (something that he felt only happened if they were in crisis) he explained how the context in which he worked influenced his approach.

'It's not just risk to the client, its risk to myself, depending on where I am seeing that client. Because I also have a practice at home I have to be cautious about that. If it's in the NHS I'll be fortunate in that there will be supervision on tap and additional boundaries in place'.

Gwen also referred to the impact on client dependency of working from home, recognising that clients could feel closer to their therapist if they had the opportunity of seeing them in their home surroundings. ***I'm sure there is all sorts of stuff going on for the client, they can fantasise that they've become part of your family, they're a friend and I think it is probably something that people need to be a lot more careful about if they are working at home without the protection of an institution.'*** She appears to be referring to issues relating to self-disclosure which are unavoidable when a client sees a therapist in their own environment.

James referred to having to be 'cautious' when working from home, suggesting he felt more personally exposed when working without the protection of an institution. He openly acknowledged that working in the NHS provides additional protection from clients who want to push boundaries, whereas in a private practice, particularly when it is from home, there are greater risks.

There is also a view that working in the NHS as part of a team provides some diffusion of responsibility for clients who become overly attached to their therapists. This is illustrated by Jenny, who explains it in this way:

'In this service we are dealing with dependency all of the time so it's not uncommon for people to, when they're giving up one dependency, to switch that a little bit and also that kind of dependency is not only carried by me it's carried by the team'

Jenny is talking specifically about clients who have a dependence on drugs or alcohol for whom, the literature suggests, dependency related issues are likely to be significant. She refers to clients being more inclined to become dependent on their therapist because sobriety is a condition of therapeutic treatment. She goes on to emphasise the importance of working as part of a team where she can share her concerns about clients, which aids her own containment and peace of mind.

The analysis of interview data indicates a belief that psychodynamic approaches which are longer term and specifically recognise dependency issues, tend to foster dependency whilst short term approaches such as CBT with its collaborative nature and focus on providing valuable tools, tend to act as a positive deterrent to dependency arising. Participants also made a link between the duration and frequency of therapy and dependency on therapists arising.

Master Theme 4: Power

All participants talked about the role of power in the therapeutic relationship, recognising that regardless of the two way relationship between therapist and client, there is inevitably inequality, with the therapist frequently being regarded as an expert by the client. This was seen to be an even greater issue where therapy was being delivered in an NHS context because of the influence of the medical model. The counterpoint to the therapist's power was their desire to encourage their clients to take responsibility for themselves; to become independent and empowered. 3 participants saw it as central to their role as therapist to encourage clients ultimately to find their own solutions and to rely on their own resources. Participants suggested that independence (having an ability to stand on one's own two feet) was a crucial factor in behavioural change, with 2 participants identifying dependency as a specific inhibitor to change.

Sub-theme 1: Dependency and the balance of power in therapy

6 out of 8 participants actively recognised and spoke about power differentials in the therapeutic relationship and the impact it had on their work and how dependency is related to this. Jenny felt that the discipline of counselling psychology has been very good at recognising the power differentials in the therapeutic relationship. Simon felt that if one was to encourage dependency with certain individuals ***'it would be an abuse of the power, the "powerful" position the therapist may find themselves in, particularly with people who are vulnerable and***

dependent and in crisis.’ He went on to talk about the role of money in therapy and how in his view it played to the power dynamic and was open to abuse, describing it as ‘a very difficult area’ saying that ***‘where money does change hands you have to be more vigilant consciously or unconsciously that you are not going to exploit this person’***. Use of the word ‘exploit’ suggests the power differential could easily lead to exploitation or abuse. This linked to what he said about a client he had helped to leave 7 years of psychodynamic therapy, who had needed to have 3 jobs to pay for it.

When listening to Rose talk there was the sense that she felt dependency was more likely to operate in a relationship where there was a lot of power vested in the therapist. She spoke in terms of this being an unhealthy situation but she showed her awareness of the complexity of the power dynamic when she said:

‘There are two people responsible for that [vesting of power]; the client ascribes the power and allows it to be there... but that’s fostered by the therapist at some level, drawn upon, but ... it’s a two way thing.’

This suggests that power dynamics only operate if both parties (therapist and client) play their part in the process.

Sarah also acknowledged power issues in her practice, referring to one client who she finds ‘really hard work’ saying ***‘she [the client] always often reminds me I am***

the one with the power really, I say when she can come and when she can't and that's true she is more vulnerable, there is an inequality there.'

Sarah also talks about how this client 'rubbishes' her, which suggests the client has some power over her; that the balance of power shifts. Her reference to 'inequality' and her use of halting speech with repetitive phrases suggests that it is difficult for her to acknowledge the innate inequality between them sometimes and particularly when her client has 'rubbished' her. When she says ***'then I have to remember her and what it's like for her and how vulnerable she is feeling'*** it is as if she has to be reminded that she as therapist has the ultimate power in the relationship.

Sarah talks about another client, who she feels had become dependent on her, but there is a sense that this is much more manageable for her. She refers to this client as a 'patient' and observes that the use of this label is ***'interesting in terms of dependency'*** and then laughs suggesting she may be embarrassed about using this term, explaining that this is what she is used to calling her psychodynamic clients. Her use of the descriptor 'patient', taken from the medical model, suggests that she sees the dynamic between herself and her client as similar to doctor and patient, which conveys an awareness of their differential status.

The existence of a power dynamic resonated with James when he talked about his belief that a collaborative approach between therapist and client should be cultivated in order to minimise power differentials in the relationship.

'it is most important, regardless of the therapeutic intervention, ensuring you are including the client in a relationship if you are not there are all sorts of opportunities for a power dynamic to build, for the client to feel undermined or that their problems are being minimised or invalidated.'

In identifying that clients may feel 'undermined' or that their problems have been 'minimised' or invalidated' it is clear James regards this as a serious matter and identifies what he sees as the risks.

'If a client feels like there is something going on in terms of relative power they may respond in any number of ways which may interfere with the process.'

He thinks the client may respond to the power dynamic by doing something the therapist, who he refers to as '***the doctor***', tells them to do, which may be something with which the client does not necessarily agree. By referring to the therapist as a doctor he is highlighting the similarity between the therapeutic relationship and the doctor patient relationship and seems to indicate that he feels the medical profession cultivates power differentials. This conclusion is supported by what he goes on to say about power issues in other parts of the profession and how psychologists should resist any temptation to exploit their clients in the course of their work.

‘Power yes, my cynical side suggests that power is something that psychiatrists use in their consultations and it’s not something a psychologist should ever use’...

James is making a very clear distinction between psychiatry and psychology and he feels strongly that ***‘rather than providing tablets from the mount allowing the client to discover what treatment options are the best for them’*** is the right approach. He is really stressing the importance of working together and not acting as an expert.

All of the participants were aware of power issues in the therapeutic relationship and whilst most felt that an equal relationship was their objective they were realistic that given the respective roles of therapist and client this was not going to be the reality. Notwithstanding this acknowledgment they felt that striving for greater equality was an entirely proper objective.

Sub-theme 2: Empowerment

The empowerment of the client as an antidote to the power of the therapist was seen by 5 participants as vital to the therapeutic process and more particularly was relevant to the process of behavioural change seen as an important part of therapy.

Gwen saw it as part of her role to empower her clients:

'the more I think about it the more important I think it is, that we help people, encourage people to basically stand on their own two feet, that's what it's all about.'

She spoke about her work as a student counsellor and how it had been her experience that when she met ***'kids away from home for the first time ... having perhaps a rather sudden introduction to trying to live independently and then floundering ... part of the work would be helping them to discover they could stand on their own feet.'***

Jenny agreed that an important part of her work with clients was ***'skills building right from an early developmental level'***. She felt that where clients had not had the opportunity to develop in a way that is not going to lead to rejection or abandonment, therapy was the ***'one place where they can start to look at all of that'***. The idea that if clients are to get well and remain well they must take ultimate responsibility was succinctly put by Valerie when she said ***'the responsibility for the treatment outcome is theirs', I can't take the problem away.'***

Rose, who was less wedded to the central role of the therapeutic relationship, felt particularly strongly about empowerment of the client. She stressed the importance of a collaborative approach and providing the client with tools to use and reuse in the future. For her the provision of useful resources, which the client could fall back on, was fundamental to her therapeutic work. She was very clear that she did not foster dependency in her clients but instead tried ***'to be useful to***

them for a purpose, which is their purpose ...' 'it's very much about enabling people to take these steps for themselves and helping them to move forward, to use what they can of it.' Rose went on to say that in terms of clients finding solutions to their problems it was so much better if they *'come up with it for themselves as it will be so much more powerful when they try it.'* She firmly believed that there was likely to be greater 'buy in' from the client if they had formulated a solution themselves rather than if it had been suggested by their therapist. Whilst James also seemed to regard the client as the ultimate arbiter of the most appropriate treatment option, he seemed to feel that therapy is more about collaboration than abdication.

'If the power is shared then you agree on an intervention then they are more likely to engage in that so rather than projecting what I think is the best thing for you to do it is more like there are a few things that we can do there are some options here how do you think it would be if you did such and such and would that work for you and how?'

The need for clients to find their own resources was also a focus for Mary, who *'won't allow people to become dependent'* on her and does not believe it is in the best interest of the client for her to encourage any form of dependence on her. She believes that helping clients to find their own resources is central to her work and that encouraging any sort of dependency would be unhelpful to this process. Mary illustrated her approach when describing working (over a 2 year period) with a female client, who was suffering from post traumatic stress disorder and who was

highly impulsive and had attempted to commit suicide a number of times. She had received a phone call from her client on a Saturday morning saying she was going to kill herself and decided, having spoken to the client's partner and given him details of the local Accident and Emergency unit, that if she ***'fell into rushing out there that nothing would change'***. She goes on to say that her client later ***'confronted'*** her about it, asking 'why didn't you come out and see me?' Mary relayed how she had explained to her client that in her judgement they had sufficient resources to cope and she wanted her to find them.

'My heart told me this is not what you must do for her it's not going to be in her best interests you are just going to keep that pattern going and sometime it's got to break, the pattern's got to break'.

She recognised that this was ***'quite a risk to take'*** and her laughter that accompanied this statement suggested some nervousness on her part about this decision but it was her firm belief that this was the right thing to do. She exercised her judgement that the client had sufficient resources to cope and her decision not to kill herself was her ultimate empowerment. She goes on to explain her philosophy on empowering her clients and is candid about how this is closely related to her not wanting to take the responsibility herself.

Simon focused on the fact that in his view therapists cannot change clients; it is for the clients to change themselves and that given the right conditions they can find their own solutions. When he spoke about what he saw as the limitations of

therapy he was clear that it was not the 50 minutes of therapy once a week that led to change it was rather ***‘the rest of their life in between sessions’***. He seemed to be very sensitive to the balance between the power of the therapist and the responsibility of the client. ***‘I suppose what I am not doing is trying too hard in a misguided way to fix it all for her because I can’t and I suppose being honest about that; so I would say to her often or fairly frequently throughout the session, when she wants to give me the decision making process about her life, to give it back to her in a sensitive manner, to remind her that she’s in charge, I can provide support ... I can offer some different perspectives at times but I can’t ultimately work it out for her, she has to.’***

He goes on to say that this client has taught him a lot about patience in that he has really just given her the time and space to work things out for herself. There is a sense that it has not always been easy for him to resist the temptation to be directive with some clients. An early experience of working with a client, who he helped to leave her psychoanalyst on whom she had become dependent, was influential in the non-directive way he now endeavours to work.

‘The brief therapy that we did, which was about 3 months, was about allowing her to make the choice to leave, to break this dependence on therapy, knowing that the door wasn’t going to close either but just to taste what it would be like for herself to break that dependence see how things go and come back if she felt that would be helpful. So I actually felt that I was empowering, I mean I, I wasn’t empowering she empowered herself.’

Simon laughed when he said 'I was empowering', seeming to realise that there was an irony in putting it that way and he corrected himself saying 'she empowered herself'. It is an interesting point he makes; how does empowerment come about? Is it entirely from within the individual or are external forces influential? The participants' views on power in the therapeutic relationship and their views on the role of collaboration in therapy suggests that empowerment is something that can be influenced or even facilitated by the therapist, echoing the notion that independence can grow if the therapist makes a 'sensitive adaptation' to the client's needs (Winnicott, 1965, p.5).

Consistent with House's (2008) view that power and control are evident in all relational dynamics, all participants were aware of issues of power in therapy. Some participants made reference to the influence of the medical model on power dynamics, likening their role to that of a doctor. Participants were however, very conscious of the need to empower their clients, focusing on the collaborative aspects of therapy as helpful in encouraging their clients to take responsibility for themselves.

Conclusion

Having analysed the participants' interview data and found the following four master themes: (i) the therapeutic relationship as the context of client dependency; (ii) feelings engendered by dependency; (iii) the impact of theoretical approach and

environment on dependency and (iv) power, the researcher will in the discussion section which follows in Chapter 5 examine how these findings fit with the literature examined in Chapter 2.

CHAPTER 5

DISCUSSION AND CONCLUSIONS

Having conducted an analysis of the data in Chapter 4 the broad findings will be examined in the light of the existing literature, highlighting the similarities and differences, and linking findings to theory. An analysis of IPA in the context of the research conducted will follow and reflexivity and contextual issues will be examined before looking at issues relating to validity and the limitations of the research. In conclusion, there will be an assessment of the implications of the findings for counselling psychology practice and for psychological theory. Finally possible directions for future research will be considered.

Research findings and links to literature and theory

The therapeutic relationship as the context of dependency

Consistent with the literature, all participants recognised the importance of the therapeutic relationship as the vehicle for the creation of a good working alliance and the provision of effective therapy. Words such as ‘fundamental’, ‘essential’ and ‘the bedrock’ for therapeutic work were used to describe the relationship, which was the acknowledged context in which dependency can arise. The participants identified a number of characteristics regarded by them as highly influential to the quality and effectiveness of the relationship, which they saw as a precursor to clients becoming dependent during therapy. These descriptors were similar to

those found in existing literature on the therapeutic relationship in that participants saw the creation of a 'trusting', 'empathic', 'congruent' relationship as a given for therapeutic work. This focus on the quality of the therapeutic relationship is unsurprising given counselling psychology's relational focus and is consistent with current research and academic thinking that the quality of the relationship rather than any specific theoretical approach influences treatment outcome (Clarkson, 1991a). 6 participants described the relationship as 'essential' or 'fundamental' to therapeutic work. Rose emphasised the importance for her of providing tools that can be utilised outside therapy rather than her relationship with the client. Whist she regarded the relationship as important this had lessened over time, which seemed to be closely related to her preference for using a CBT approach. Rose's attitude to the importance of the therapeutic relationship is consistent with historic research where therapeutic technique has been regarded as more important than the therapeutic relationship by CBT practitioners (Ellis, 1967). Even so, consistent with the view of 7 participants, this view is changing, with the literature now recognising the importance of the relationship for CBT (Gilbert and Leahy, 2007).

All participants regarded the use of firm boundaries as an important way of minimising client dependency, although the length of their experience seemed to be directly related to how comfortable they felt about relaxing boundaries. Gwen, who had 22 years of counselling experience, felt happy for clients to contact her outside of sessions as was Mary, with 10 years experience and Sarah with 8 years experience. Participants with less experience (Jenny, Simon and James) were far

more circumspect about out of session contact. In the case of the less experienced participants there is a risk that their attitude to maintaining boundaries may have the effect of forcing them into defensive practice and not providing clients with the optimum therapeutic environment (Totton, 2010). Length of experience seemed to be strongly influential on how dependency was conceptualised and how it was worked with by participants. Those with greater experience were much less concerned about dealing with dependent clients but acknowledged their attitude had changed during the course of their careers. This is consistent with the findings of Caracena (1965), who identified that the more experienced a therapist the more likely they were to raise issues of dependency with clients.

Experiences of clients displaying dependent behaviours early on in participants' careers seemed to play a part in their subsequent attitude to client dependency. Half of the participants had personally experienced or had witnessed problematic relationships where clients had become overly attached or reliant on them or a colleague. This experience seemed to result in them fearing clients becoming dependent on them, which in turn coloured their approach to clients who displayed dependent behaviours. Half of the participants focused on the collaborative nature of their approach to therapeutic work, which they believed acted as an 'antidote' to clients who are 'needy', ask for more sessions, seek contact outside of sessions, stay for more than the allotted time and are 'overly reliant' on their therapist (Bornstein, 2005). This half of the participants believed that through their actions they can, if not entirely prevent, actively discourage a client from becoming

dependent. This can be contrasted with psychodynamic thinking that dependency is unconscious and is informed by early childhood experiences (Freud, 1905), which was the view subscribed to by Simon and Sarah.

If therapy is seen as providing the environment for clients to re-experience their early object relationships (Freud, 1905) it is highly likely that some clients will display dependency needs as the therapeutic environment is considered to be safe and containing. Relevant to this is society's stance on vulnerability, which impacts the behaviour of both therapists and clients when confronted with dependency needs. Layton (2009) writes about what she refers to as 'neoliberal subjectivity' (p.105), which is subjectivity marked by a repudiation of vulnerability. She sees this as having arisen in a changing society over the past 30 years and argues that the defence mechanisms involved in this repudiation have led to a reduction in the capacity for empathy, which in turn has reduced our feelings of responsibility and accountability for another's suffering. This could provide an explanation for participant's reluctance to approach dependency in their therapeutic work as their attitude to empathy allows them to maintain a safe distance from their client's suffering. Layton (2009) argues that where public institutions abandon their responsibilities towards their citizens there is a pressure for individuals to become more individualistic and in so doing they reject 'the vulnerable and needy parts of the self' (Layton, 2009, p. 106). This may go some way to explaining why clients failed to display dependent behaviours – because they live in a society where the

idealised self 'eschews long term dependency on others' (Sennett, 2006, p. 177) and such displays are not permitted even in therapy.

The majority of participants spoke about dependency as something that they tried to resist if it became apparent in their clients, with Jenny, Rose, James and Mary either failing to acknowledge dependency needs in their clients or taking steps to discourage it. For Simon and James discouraging dependency involved being very firm about the limitations of therapy at the outset and in the case of Rose, James and Mary actively encouraging autonomy. If participants have a strong desire to push away dependency and not acknowledge neediness because of their own desire to reject responsibility for their clients it is likely they may find acknowledging such uncomfortable dynamics to a researcher difficult. Whilst every effort was made to make participants feel comfortable during the interview process there is inevitably something daunting about speaking about difficult feelings to a stranger, particularly one who is going to analyse every nuance of what is said and even what is not said. This may be particularly difficult with a fellow professional where the balance of power in the relationship may be influential. Societal power dynamics, which cannot be avoided in the therapy room (Guilfoyle, 2007), are likely to be present in a research interview about therapeutic practice and therefore need to be acknowledged. These dynamics may have resulted in participants feeling subjugated and accordingly less likely to share difficult experiences.

Feelings engendered by dependency

When participants spoke about dependency they used a variety of expressions to describe the phenomenon such as 'reliant', 'needy', 'overly attached', 'too close', 'glued' or 'stuck' together. Gwen also used the adjective 'unhealthy'. The use of these descriptors provides further evidence that participants saw dependency in a negative light, which reflects society's narrative that regards vulnerability and need as something shameful to be avoided (Layton, 2009). These descriptions are consistent with those found by Tait (1997), where her participants described feeling 'smothered' and 'manipulated' in relation to their experiences of dependency.

Jenny sometimes used the term 'attachment' when describing dependency, suggesting she equated the two concepts or perhaps she found the term attachment more palatable. Sarah, who described dependency as a 'powerful infantile' feeling, was very clear in her mind about the psychodynamic distinction between dependency and attachment, and was reluctant to describe herself as being 'dependent' on a client but was happy to use the term 'attached'. Again her attitude seems to reflect the notion that dependency is something negative that she was not willing to acknowledge in herself, whereas attachment to another was more acceptable. A historical link exists between attachment theory and psychoanalytic theory, from which the concept of dependency emerged, and as a consequence the literature treats dependency and attachment as being closely related. This link seemed to exist in the minds of Jenny and Sarah who used both terms in their narrative but was not something referred to by other participants.

The absence of any mention by participants of the attachment style of their clients was notable. Also absent was any specific reference to their own attachment status, which would have influenced the relational dynamics between therapist and client. Mary got the closest when she identified her unwillingness to allow clients to become dependent on her, saying this was because she was not 'hot on intimacy'. Sarah also made reference to her own formative experiences when she described her reaction to her client's anger. The failure to pursue this acknowledgement of the impact of the therapist on the relationship with the client ignores relational psychotherapy theory, which sees the task of therapy as a co-construction between therapist and client (Mitchell, 1988). On questioning why the impact of the therapist's attachment style on the relational dynamics with their clients was not pursued either with Mary or other participants, I believe this mirrored the reluctance of participants to look at their role in the dependency phenomenon. In effect an environment in which there is a reluctance to consider dependency issues may have been co-created with the participants, which is consistent with attitudes prevalent in society today (Layton, 2009).

Peltz (2005) has argued that when governments abdicate responsibility for containing anxiety and protecting the vulnerable and the needy, dependency becomes increasingly shameful. This may provide an explanation for participants defending their stance that dependency should not be fostered and that self-sufficiency and autonomy were primary therapeutic goals. Their avoidance of dependency is understandable by virtue of the fact they reflect the values of a

society, which is increasingly an individualistic meritocracy (Sennett, 2006) and sees independence as important, rejecting vulnerability and neediness. In such a society its citizens become less responsible for others, with the split of the individualist from the social individual causing 'a crisis in empathy, responsibility, and accountability' (p.108).

In contrast to most other participants, Sarah thought client's experiencing their dependency needs was as an important part of therapy. Her view is consistent with psychodynamic theory, which sees individuals as having to move from a dependent state to an independent one (Freud, 1905). Where therapy is seen as a place to re-experience early formative relationships, then having dependency needs met by the therapist can provide a route to independence. This parallels the process identified by Winnicott (1965) when he described independence as 'something that is achieved out of dependence - this growth (towards independence) cannot take place unless a very sensitive adaptation is made by someone to the infant's needs' (p.5). Sarah's view that working with dependency was central to her therapeutic work is consistent with the findings of Tait (1997) where the majority of her participants regarded dependency as a necessary phenomenon in therapy on the path to wellbeing and personal autonomy. The implication being that dependence precedes independence, which is the implicit therapeutic goal, supporting Layton's (2009) assertion that we live in a society that values independence and repudiates vulnerability.

The feelings participants described experiencing when clients became dependent on them is not something that has previously been researched in any detail. The accounts given by participants were extremely powerful and the feelings they experienced had a significant impact on their therapeutic work. 6 participants had experienced some very challenging feelings when clients had exhibited strongly dependent behaviours, ranging from fear and anxiety to rage and anger. Sarah described how she experienced a physical reaction: shaking all over in response to a particular client; but she recognised this as the 'price to pay' if a client's powerful infantile dependency needs were to be explored in the course of therapy. Sarah's view is consistent with the conclusions of Levitt et al. (2006), who found that a dependence on the therapist during the initial stages of therapy, which tapered off as therapy progressed, allowed the client to individuate from significant others, seen as crucial to achieving greater self reliance. Notwithstanding the therapeutic benefits of working with dependency, Sarah was still left feeling 'angry', 'rubbish' and 'impotent' as a consequence.

The strength of feeling expressed by participants who encounter or resist dependency needs indicates that this is a highly complex problem for them in their practice, which is little discussed in training circles but seems to cause significant concern and even distress to therapists. Notwithstanding the level of distress described, only 2 participants made reference to taking these issues to supervision and even then these references were oblique. These findings suggest that the impact of actual or anticipated client dependency is something that needs to be

more fully examined and discussed in training programs and is something that supervisors should have a greater awareness of.

The split of the individualist from the social individual in our society can be seen as leading to the repression of feelings such as dependence and vulnerability and also encouraging individualistic identities (Layton, 2009). Where these feelings are repressed this can lead to individuals defending against exposure of their own relational longing. This may result in therapists seeing themselves in the same way as society perceives them, as superior to others and far removed from need and vulnerability (Layton, 2009). If, as is suggested, this results in mutual dependency being denied it is understandable that participants would find it difficult to acknowledge let alone speak about their own dependent feelings towards their clients. Gwen and Valerie were the only 2 participants who touched on these mutual feelings, referring to feeling 'stuck' or 'glued' to clients, conveying a sense that there was no means of escape. There was a suggestion of a desire to escape, suggesting a blocking of awareness of any feelings of mutual inter-dependence.

Valerie was the only participant who spoke about how she and her client could not 'let go of each other'. Whilst the literature draws a link between dependency and a client's reluctance to leave therapy (Bornstein, 2005) there is very little literature concerning the difficulties experienced by therapists in this context. This lack of evidence can be viewed in the context of a similar lack of research into therapist's feelings of attraction in the therapeutic relationship. Attraction has been examined

in depth from the client standpoint but only to a much lesser extent from the therapist's perspective (Pope et al. 1986). When the subject of therapist-client attraction first appeared in the literature, discussion was almost exclusively in terms of transference and counter-transference (Tower, 1956). In this context any feelings the therapists had for their client were ascribed to counter-transference and as such were seen to involve a distortion on the part of the therapist and viewed as an inappropriate response to the client's transference. This resulted in therapist attraction towards their client being seen as 'a therapeutic error, something to hide and to be ashamed of' (Pope et al. 1986 p.150). A sense of shame was apparent when Valerie spoke about not being able to let go of her client, whispering about how long they had worked together as if it must be kept secret. Similarly Gwen conveyed a sense of shame in her account of her continued work with a client during the time she was ill herself. It may be possible to understand her reaction in context of Tait's (1997) finding that the therapist's response to a dependent client can be uncomfortable because it highlights the therapist own need to be taken care of.

Gwen and Valerie both described feeling 'seduced' by clients who wanted more of them than they felt able to give, which left them feeling violated. Winnicott (1949) encouraged an examination of therapists' negative feelings towards their clients, regarding it as important for therapists to 'not deny that hate really exists' (p.70) because denial would lead to 'therapy that is adapted to the needs of the therapist rather than the patient' (p.74). Notwithstanding this early acknowledgment in the

literature of the impact of these difficult issues, subsequent research has been largely neglected (Pope and Tabachnick, 1993). Tait (1997), however, when looking at whether dependency was a means or an impediment to growth, found it was the source of much discomfort for individuals working in helping roles, including counsellors, with participants describing feeling 'scared' 'smothered' and 'manipulated' by clients who became dependent (p. 22). Fear is illustrated in Jenny's narrative where she admits being thankful she had not been 'fearful' or 'actually been in really nasty situations'. She refers to 'attachments' formed between other professionals and clients as having 'very sinister edges'. Where therapist fear has been explored in the literature the focus has been on physical rather than psychological fear (Pope et al. 1986) and so this area is also somewhat neglected.

Impact of the theoretical approach and the environment on dependency

There was a consistent view amongst participants that psychodynamic approaches, which actively acknowledge the role of dependency in therapy and which tend to be longer term, fostered dependency whilst short term approaches such as CBT tend to act as a positive deterrent to dependency arising. This was thought to be so because more collaborative approaches had a greater focus on providing lasting tools for clients, which half of the participants saw as actively promoting and encouraging independence.

Participants worked in a variety of settings, which they regarded as relevant to the likelihood of dependency arising. Those working within the NHS acknowledged that in general they were constrained by the number of sessions they could offer a client, which they thought reduced the likelihood of a serious dependency arising. There was also a belief that working within an institution provided protection for therapists from clients becoming overly dependent on them. James acknowledged that working in the NHS meant that if clients in crisis contacted him out of hours he could direct them to other support systems rather than relaxing his boundaries and agreeing to see them himself. He contrasted this with working from home, where he felt he needed to be very careful to protect himself. Gwen also identified additional risks for herself when she worked from home, saying she thought clients felt closer to their therapist and might therefore fantasise that they had become 'part of her family'. She also made several references to what she regarded as the benefits of working with the protection of an institution, implying that this made her feel safe. This feeling of protection can be explained by the fact that the NHS, as an institution of the state, espouses society's values, which repudiate dependency and need (Layton, 2009). Participants are embedded in society and therefore mirror the institutions' attitude to dependency. This reinforces their denial of responsibility for others and thereby allows them to feel justified in their view that autonomy and self-sufficiency are to be valued.

The literature strongly supports the role of early childhood experiences as a major influence of adult dependency needs. This thinking was supported by Sarah, who

found that it very much depended on the individual client history as to whether dependent behaviours were exhibited or not. Jenny, Valerie and James, who all worked with individuals dependent on drugs or alcohol, also openly acknowledged the impact of the client's history on dependency. They identified that clients, who were dependent on drugs or alcohol, frequently transferred that dependency to their therapist, which they regarded as an inevitable risk of their work. The experience of Jenny, Valerie and James is consistent with psychodynamic theory that orally fixated individuals will remain dependent on others for nurture and support into adulthood and will continue to exhibit behaviours that reflect the infantile oral stage such as a preoccupation with activities involving the mouth, often with a reliance on consumption as a means of coping with anxiety in adulthood.

Power

Totton (2006) sees psychotherapy as building in 'stubborn problems of power and control' and acting as an environment in which power is surrendered to 'a regime of expertise'. 'Therapists inherit powerful speaking positions from the institutional and sociocultural context, and any rejection of power in therapy serves only to conceal this aspect of power, which nevertheless pervades the therapeutic relationship' (Guilfoyle, 2003, p. 331). As a consequence Guilfoyle (2003) believes that therapists, as 'inheritors' of power need to include the influence of power in their understanding of the therapeutic process. Consistent with this, all participants were aware of power issues in therapy, seeing it as relevant to the

dynamics operating in their therapeutic relationships. Power in therapy also links to the cognitive aspect of Bornstein's (1993) conceptualization of dependency as 'a perception of the self as powerless and ineffectual whilst others are powerful' (p.8) making it more likely that issues relating to power will be present with dependent individuals. Valerie, Rose and James, who worked in the NHS, referred to the influence of the medical model saying they appeared to be perceived as experts, which they believed influenced the power dynamics.

Sarah related how one particularly dependent 'patient' of hers had observed that all the power was vested in her as therapist because she had the ultimate control about whether and when she would see the client. Sarah's account of her clients' perspective on the power dynamics in their relationship was consistent with the views of Tait's (1997) participants, who feared therapists might abuse their power where clients became dependent on them. Participants' apparent awareness of the influence of power on the therapeutic process suggests they were reflecting on the issue in a critical manner and that they recognise their immersion in power dynamics (Hook, 2003). It is also possible that the power dynamics within therapy had another influence on dependency issues. If the therapist is seen as powerful, then clients may see themselves as weak or in some way subjugated to the therapist. This may be so even if they do not necessarily perceive themselves as powerless (Bornstein, 1993).

Smith (2009) said that for the purposes of obtaining good quality data, power differentials need to be negotiated so that participants feel at ease. Heidegger's (1927) phenomenological concept of 'dasein' is concerned with being thrown into a world of people, language and culture, recognising the impossibility of being detached. The inability of me, as researcher, to be detached was in evidence on examining the recording of the interview with Valerie (Appendix 6), where there was evidence of a power dynamic in operation. This may have been influenced by the respective roles of interviewer and interviewee, which from a power perspective could be regarded as akin to therapist and client. The interaction with Valerie prior to the interview, when she had joked about the research being for a doctoral thesis and that she was not herself a doctor, provides some evidence that power issues were present during the interview and that she may have felt subjugated during the interview process.

It has been suggested that power can obstruct or compromise dialogue in therapy, constraining a client's expression (Anderson, 2001), which may also apply to the interview process and could have resulted in an unwillingness to discuss difficult issues relating to dependency. However, there is some evidence that Valerie may have countered power with resistance as she was prepared to talk about some distressing personal experiences with the result that the interview data was rich in content. It is possible that the influence of power dynamics in the research interviews may have had an influence on the willingness of all participants to discuss difficult material.

All participants agreed that they would discuss dependency issues with clients if they arose and try to work with them. James and Rose had not experienced clients becoming overly attached to them and associated this with their taking active steps to discourage dependency by being collaborative and empowering of their clients. Alternatively this can be explained by examining therapy against the back drop of a society that values independence and provides no room for expressions of vulnerability. Consistent with a rejection of neediness and dependency was the approach of Simon and Mary, who had experienced clients becoming dependent on them, but who also took active steps to encourage independent behaviours, firmly believing that empowering clients to make their own decisions and take responsibility was an important part of therapeutic work. Although Gwen felt dependency had to be worked through to achieve a state of healthy independence, she and Mary believed that 'neediness' prevented clients taking responsibility and therefore saw dependent behaviour as a barrier to a positive treatment outcome. The view that old patterns of behaviour could only be broken if a client found their independence and a greater level of autonomy is on all fours with Layton's (2009) view that we live in a society where vulnerability is rejected and self-sufficiency is supreme.

Finally the researcher wishes to reflect on the implications of the research findings for the discipline of counselling psychology. In this context it may be worthy of repetition that Counselling psychologists, who take a relational approach to their work, having a central belief that the therapeutic relationship involves working towards an authentic meeting of equals, with a focus on enhancing self-

determination and the client reaching their full potential (Woolfe et al. 2003). This is an appropriate objective and given the findings of Feeney (2007), supporting the views of Winnicott (1965), that a sensitive handling of dependency needs in therapy leads to greater levels of empowerment and autonomy rather than greater levels of dependent behaviour.

When speaking about their experiences of dependency the participants had used pejorative descriptions, which conveyed a reluctance to approach dependency needs in their clients, describing it as 'unhealthy' 'reliant', 'needy', 'overly attached' and 'too close'. Also apart from Sarah, who recognised the importance of working with dependency and Gwen who would now be circumspect about dependency, the other participants either, denied the existence of dependency needs or, rejected the need to address them in therapy or, worked hard to discourage them. These descriptions and these attitudes seem to demonstrate the participant's unwillingness to approach dependency issues with their clients and the implications of this unwillingness seem worthy of further reflection.

The use of pejorative descriptions of dependency by participants can be understood as mirroring society's narrative that sees vulnerability and need as shameful (Layton, 2009). However, given the ethos of counselling psychology, with the relational at its very centre, these findings suggest there is a tension between the theoretical underpinnings of the discipline and what happens in practice.

Participants in the main seemed unwilling to recognise or allow dependency to operate in their therapeutic relationships, which can be understood as a core relational need of their clients, and this reluctance seems to strike at the very core of the discipline, which involves an authentic meeting of equals.

The research findings suggest that this tension between the relational ethos of counselling psychology and the participant's perception, understanding and experience of dependency is also influenced by the context in which participants work. All participants worked in, or had recently retired from, the NHS, which as an institution of the state is likely to espouse values that are consistent with a society that rejects vulnerability and need (Layton, 2009). The drive in the NHS towards delivering CBT in a time limited number of sessions, with the focus on patient empowerment, is likely to further fuel the reluctance of counselling psychologists to approach the dependency needs of clients in a sensitive manner. However, this focus in the NHS on CBT, with collaboration and the provision of skills rather than the relational at its heart, which rejects dependency needs, ironically may lead to less autonomy and patient empowerment rather than more. This suggests that the very nature of the therapeutic approach used may in fact operate to defeat its intended purpose and with this there are implications for patient wellbeing and NHS resources.

Using IPA

IPA was developed by Smith (1996) 'to allow the rigorous exploration of idiographic subjective experiences and, more specifically, social cognitions' (Biggerstaff & Thompson, 2008 p.215). Its use has facilitated access to participants' views, perceptions, reactions, attitudes, opinions, thoughts, and experiences allowing 'patterns and meaning to emerge' (Smith & Osborn, 2008, p.246). Deeper insight into the views and experiences of participants has been obtained than might be the case if positivistic empirical methods had been used. By using a method, which focuses on how social experience is created and given meaning, an attempt has been made to understand the participants' experience in depth and to make sense of the phenomenon of dependency in terms of the meanings they bring to the concept (Denzin & Lincoln, 2000). It has enabled a detailed in-depth analysis of a particular group of Counselling Psychologists' lived experience of dependency in the context of their therapeutic practice.

IPA is regarded as a suitable methodology for exploring 'flexibly and in detail, an area of concern' (Smith & Osborn, 2003 p.53), aiming to provide an understanding of being in the world rather than necessarily seeking to add to knowledge (Heidegger, 1962). This has made it suitable for the exploration of dependency in therapy. It is concerned with particularity rather than the general, being interested in capturing a particular experience as experienced by a particular set of participants and not necessarily in trying to substantiate more general claims. IPA is interpretative and therefore has the capacity to make links between the

understandings of participants and theoretical frameworks in mainstream psychology, which has resulted in novel information about dependency in therapy. It has also been possible to examine the convergence and divergence of participants' views as a way of uncovering a wide range of experience rather than obtaining a more conceptual level of analysis to support a theoretical standpoint, as is the case with grounded theory.

The influence of phenomenology, which has at its heart an interest in the experience of being human, has resulted in a methodology which can produce 'a rich source of ideas about how to examine and comprehend lived experience' (Smith et al. 2009, p.11). Identification of the essential qualities of a participant's experience requires them to be reflective about those experiences and so time and space was provided during interviews for participants to think about their personal experience of dependency. They were also given the opportunity to add or amend their interview transcripts which, for Rose, Simon, Sarah and Mary resulted in changes and additions following further reflection. Rose observed that she had not previously reflected on some of the issues that arose during the interview and felt she could have talked in more depth given time. Her observations led to consideration of the need for follow-up interviews with all participants but this had to be rejected due to logistical difficulties.

The double hermeneutic performed by the researcher when using IPA - trying to make sense of the participant making sense of their experience of dependency – could be argued to prevent an exploration of unconscious processes operating both during the interview or between therapists and clients. However, this is addressed in the process of analysis and interpretation of data, both grammatical and psychological, described by Smith et al. (2009, p.23) as ‘added value’. The attempt to offer meaningful insight and theoretical explanations for the data generated, which goes beyond the explicit claims of participants can bring the unconscious experience of the participants to the fore. The interpretative nature of IPA has allowed theory to be used to offer an explanation for the data and to interpret participant’s reactions to dependency as shame and worthlessness, which were not words used by participants. This ability to offer interpretation allows the researcher to read between the lines and is therefore important in terms of revealing hidden meaning behind the reluctance to acknowledge the existence of dependency. Emotions are central to human experience and their exploration is a strongly prevailing theme in IPA (Smith et al. 2009). The emotions identified by participants in the context of their experience of dependency were profound, with fear, anxiety and guilt all being directly owned.

In order to ensure the necessary focus on the research question a homogeneous and purposive sample of participants were interviewed. However, their experience of dependency in therapy was uniquely embodied, situated and taken from their own particular perspective (Smith et al. 2009, p.29). Merleau-Ponty’s (1962) idea of

embodied knowledge, regarded the body as a means of communication with the world, which is relevant to the experience of being in the world. The body reminds individuals of emotions. In the case of Sarah, who described shaking and trembling with anger in response to a client, who had become dependent on her, this embodied knowledge illuminated her experience of being with a dependent client, adding richness to her account. Gwen used a physically descriptive metaphor to describe her experience of her client's unhealthy reliance on her, describing them as 'glued' together and Valerie spoke in terms of being 'stuck' to her client.

IPA recognises the central role of the researcher in making sense of the participant's personal lived experience (Smith, 2004). It is through this interaction of participant and researcher that meaning emerges. The researcher's embodied position is also relevant as they perform their role of interviewer, colouring their experience of being with the participant, which requires reflexive awareness. It may be possible to empathise with participants' experience of dependency but not to actually share their experience. This is recognised in the statement that 'the analytic process cannot ever achieve a genuinely first person account – the account is always constructed by participant and researcher' (Larkin, Watts and Clifton, 2006, p. 104). The impossibility of ignoring the impact of the researcher and the extent to which any method can really provide access to the personal world of the research participant is a key area of debate in qualitative research. All that can be done is to acknowledge the difficulty of escaping one's own preconceptions and do a sensitive and responsible job. In any event these difficulties should not prevent

the phenomenon of dependency being revealed on 'its own terms' (Larkin et al. 2006, p. 108). Even though it was not possible to 'suspend any existing knowledge of the field and personal experiences within it' (Flowers, Smith, Sheeran and Beail, 1998, p. 412), as one becomes more deeply immersed in the data it is possible to recall every nuance of the participant's account, with the result that interpretations are firmly grounded in the participant's narrative.

Collins and Nicolson (2002) have argued that detailed engagement with the text during the analysis stage, particularly the breaking down of the narrative into words and phrases, is tantamount to a dilution of the data. However, it was during the analysis phase that the narrative of the participants came to life, as meaning was uncovered and words interpreted. This was particularly so when participants described the feelings they experienced when encountering or withstanding dependency. To the extent any dilution of data did occur, the writing up process provided a further opportunity for the participants' experience to re-emerge (Smith, 2004).

Reflexivity

The central role of the researcher in IPA necessitates an examination of the impact of their personal and professional stance on the research process, analysis and findings.

The influence of power has already been discussed in relation to the interview with Valerie (Appendix 6). Present in this interview and more generally was a propensity to directness on the part of the researcher, which may have influenced or restricted the data obtained, with the possibility that at times this may have closed things down rather than opening them up. This can be explained by the purposive nature of the research interview and my previous role as a senior lawyer, who was used to adopting a direct manner in a professional setting.

The findings indicate that only Sarah regarded client dependency as particularly important in her practice and whilst Gwen and Valerie were tolerant of dependent behaviours in their clients, the remaining participants reported either, not experiencing dependency, being wary of it or, taking active steps to avoid it. Although theoretical explanations have been offered to explain this it is also possible that the researcher's personal stance on dependency, which is consistent with the majority of participants - avoiding becoming dependant and shying away from others depending on her - may have created, either at the time of interview or in the analysis of the data, a bias in favour of participants who expounded similar views.

Contextual Issues

The participants, who worked in the NHS at the time of interview, seemed acutely conscious of the limited amount of time they could dedicate to clients, with Valerie

and James acknowledging the impact of budgetary constraints, the NICE guidelines on treatment models and the influence of the medical model. Jenny, Valerie and James worked in drugs and alcohol, where the literature provides that individuals suffering from addictions are more likely to have dependency issues, which may surface in therapy (Bornstein, 1992). This made it more likely that these participants would have experience of working with dependent clients, resulting in some rich descriptions of the phenomenon. Whilst they all recognised the theoretical link, only Valerie was able to provide clinical examples, providing little support in the data for the connection between dependency and addictions.

Validity

The central role of the researcher in IPA made it difficult to evaluate it as a methodology because traditional criteria for judging effectiveness, such as the use of representative sample or the production of statistically significant analysis, are not relevant. Efforts were made to minimise these issues by having another counselling psychologist review the analysis, not to prescribe 'the singular true account' (Yardley, 2000, p.69) but to lend credibility of the researcher's account. The inclusion of quoted extracts also makes it possible for the reader to evaluate the analysis and thereby assess the power of the account.

The general guidelines proffered by Yardley (2000) for assessing the quality of the research were adhered to. *Sensitivity to context* was demonstrated by locating the

phenomenon of dependency being investigated in the literature and by recruiting a purposive sample of Counselling Psychologists. Good quality interview data was sought by using counselling skills to create a rapport with participants and all participants were asked for feedback on the interview and the process (Kvale, 1996). In addition memos and reflective summaries were made immediately following each interview, which were consulted during the course of writing up the research. The need for sensitivity continued into the analysis phase, where disciplined attention to the unfolding account of the participant can be seen from the line by line analysis of the data (see Appendix 6). *Commitment and rigour* was achieved by ensuring that emerging interpretations were grounded in the experience of the participants. The analysis was conducted thoroughly and systematically and is sufficiently interpretative not purely descriptive. By ensuring the research process has been thoroughly and accurately described '*transparency and coherence*' has been adequately demonstrated. Yardley's final principle of '*impact and importance*' can be demonstrated by the findings having implications for training and practice, examined below.

Weaknesses of the research

Whilst the researcher sought to adhere closely to Smith's (2004) guidelines for IPA by recruiting a broadly homogeneous sample of Counselling Psychologists to illuminate the research question, they seemed to lack any real identification with the discipline of Counselling Psychology. Whilst this may have implications for this

branch of the profession, the findings are capable of broader application to psychotherapy and counselling as a whole.

The researcher was aware that self-selection of research participants is difficult to avoid in that only those who have an interest in the research question are likely to volunteer to participate. This was illustrated when Jenny and Simon observed how pleased they were that dependency was being investigated. In both cases they had experienced client dependency, either directly or indirectly, and as a consequence both were extremely troubled by the prospect of clients becoming dependent on them.

Contribution and implications for training, supervision and practice

The findings support and build upon the work of Tait (1997), who recognised the need for more rigorous research into the management of client dependency and its impact in therapeutic work. By examining the participant's lived experience of dependency in the context of their practice, valuable insight into their perceptions and understanding of dependency emerged. This can be used to expand practitioners' awareness of the implications of approaching or avoiding dependency in therapeutic relationships and thereby further inform ways of working with dependent clients and issues of dependency.

The reluctance of participants to acknowledge dependency issues in their clients or to engage in discussion about these issues with the researcher, which can be understood against the backdrop of individualistic western societal values, with its increasing lack of empathy (Layton, 2009), identifies something new that has been little acknowledged in psychological research. There is support in the findings for Peltz' (2005) work, who has argued that where institutions abdicate responsibility for containing the vulnerable and the needy dependency becomes increasingly shameful and therefore harder to demonstrate or acknowledge. This leads to vulnerability being rejected with the result that an experience of empathy is fostered in which therapists 'can sustain a safe distance from the suffering other and not hold oneself as accountable' (Layton, 2009, p.105). In a profession where empathy is generally regarded as a cornerstone of therapeutic engagement this has important implications for practice and the training of therapists, where this reality needs to be acknowledged if therapists wish to be authentic with their clients.

Given counselling psychology's focus on the therapeutic relationship and on enhancing client self-determination, the reluctance of participants to approach client dependency in therapy may well have implications for the discipline of counselling psychology as a whole, which need to be considered by the profession. The impact on client wellbeing from failing to handle dependency needs in a sensitive fashion also has implications for mental health resources, which need to be considered by professionals and policy makers alike in the context of a drive towards a CBT approach in the NHS, with less focus on the relational aspects of therapy.

The awareness of all participants of the influence of power on the therapeutic process suggests they recognise their immersion in power dynamics (Hook, 2003). They appeared to be cognisant of the powerful position inherited by therapists from institutional and socio-cultural contexts (Guilfoyle, 2003). Connected to this was participants' belief that longer term approaches tended to foster client dependency and reinforce the powerful role of the therapist. This was in the context of negative views about displays of dependency, which reflect a society that repudiates vulnerability and neediness (Layton, 2009). The impact of power in therapy needs to be seen in the context of the relational approach favoured by Counselling Psychologists where the client's previous relationships inform an understanding of their current relationships. The therapeutic relationship creates a space where such relational dynamics are provoked and can be worked through. The implication is that as well as the therapist's own relational position, which will depend on their personality and training, the dynamics between therapist and client will be infused with issues of power. It is important to acknowledge and examine how these dynamics impact the therapeutic process. Issues of power have implications for policy and are topical in therapeutic circles, with the move towards greater public access to therapy. The focus in the NHS on short-term CBT, which puts greater emphasis on the collaborative nature of therapy, aims to equalise power differentials.

The finding that the majority of participants had experienced extremely powerful and challenging feelings when working with dependency has implications for

training and supervision. These feelings were difficult to speak about and consequently were not readily discussed in supervision, leaving the therapist managing alone something that can be highly anxiety provoking. This suggests that the impact of dependent clients needs to be more fully examined and discussed in greater depth in training programs and is something of which supervisors should have greater awareness.

Also of significance for training and supervision is the finding that inexperienced practitioners seem more inclined to avoid rather than engage with dependency behaviours in their clients, whereas more experienced therapists are more comfortable working dependency. This leads to a tentative recommendation that a minimum level of experience may be helpful when working with clients, who have identified dependency issues.

Increased awareness of the role of dependency in the therapeutic relationship and in influence of power differentials has implications for the researcher's own therapeutic practice. The knowledge that these are difficult issues, which are easy to turn away from in a society that repudiates vulnerability, has led to a greater focus on these issues in practice. The implications for empathy, coupled with the knowledge that sensitive handling of dependency issues may pave the way for a client's greater autonomy, has encouraged me to address the challenges of working dependency in my own practice.

Further research

Participants' reluctance to acknowledge dependency or to reject it in favour of autonomy and the assertion that empathy has been diluted, and with it a responsibility for clients, suggests that further research into the implications for practice may be fruitful. The depth of feeling experienced by therapists when, either avoiding dependency or, working with dependent clients suggests there are serious implications for therapists' wellbeing that need to be better understood.

The single account given by Rose of her personal experience of becoming dependent during therapy was very moving and provided greater insight into how dependency is experienced from a client's perspective. Given the richness of this account, conducting further research from a client standpoint may be valuable in providing additional insight into how clients experience therapists, who either foster or repudiate dependency and vulnerability.

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